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The Training Environment in General Practice and Preparedness for Practice

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List of Acronyms

AHP- Allied Health Professionals

CCT- Certificate of Completion of Training

CSA-Clinical skills assessment

ECGP- early Career General Practitioner

GMC- General Medical Council

GMS- General Medical Services

GP- General Practitioner

GPST- General Practice Speciality Training

GPT- General Practice Trainee

HDR- half day release- educational meetings of GP trainees

LHCC- Local Health Care Co-operative

MMC – Modernising Medical Careers

MRCGP- membership of the Royal college of General Practitioners

NICE-National Institute for Clinical Excellence

nMRCGP- new membership of Royal College of General practitioners

PCT – primary care trusts

PBSGL- Practice Based Small Group Learning

PMETB- Postgraduate Medical Education Training Board

QOF- Quality and Outcomes Framework

RCGP- Royal college of General Practitioners

WPBA- Work place Based Assessment

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For every complex problem there is an answer that is clear, simple, and wrong. (H. L. Mencken)

Abstract

This thesis explores the way General Practice trainees and early career General Practitioners describe their training environment in General Practice, the meaning they attach to the notion of preparedness and their perceptions of the impact of the training environment on their preparedness. The study was informed by the interpretivist paradigm. I conducted 27 in-depth semi-structured interviews with 15 early career General Practitioners and 12 General Practice trainees at the end of their training. Interview data were transcribed and analysed thematically, drawing partially on the grounded theory approach of data analysis.

Interviewees described their training environment in terms of their sense of being included in the Practice, the Practice ethos, the importance of training within the Practice, the trainer and their relationship with the trainer. There was no unanimous way in which interviewees talked about preparedness, however the meanings attributed to preparedness centred around two central elements ‘confidence’ and ‘adaptability’ and included: working independently and being self directed; knowledge of business and partnership issues; ability to manage patients and workload; good consultation skills and effective time management; and adequate knowledge and passing the RCGP CSA examination.

The way the training Practice can impact on trainees’ preparedness was explained drawing on Bandura’s theory of ‘self efficacy’ and Lave and Wenger’s theory of ‘situated learning’. Inclusive training Practices, characterised by less hierarchical relationships between the doctors, particularly vis-à-vis trainees, were better at preparing trainees for their future role by affording them greater opportunities to take part in a wider range of General Practice work. The role of the trainer was also pivotal in preparing trainees through effective teaching. Supervision tailored to trainees’ needs, and guided decision making enhanced confidence of trainees in their ability to work independently.

The findings from this thesis might be of an interest to policy makers and can be used to inform the quality assurance framework of postgraduate medical training and the design of GP training programmes. The study offers new insights into the notion of preparedness and adds that preparedness is not only manifested by self-confidence but also by the ability to adapt to future work. In addition the study suggests that for trainees to be better prepared what matters is not simply the length of time spent in training but rather the nature of the training environment, the opportunities afforded to trainees and their engagement in such opportunities.

Chapter 1: Introduction

This thesis explores descriptions by General Practice trainees (“GP trainees”) and early career General Practitioners (“ECGPs”) of their training environment in General Practice, their interpretations of the notion of preparedness and their perceptions of the impact of that environment on their preparedness for practice.

I begin by describing my motivation for conducting the research and provide some background information to explain the context in which the research took place (Chapter 1). I continue by providing a literature review as a background for the research (Chapter 2) and the methodology and methods employed (Chapter 3). Chapters 4-6 outline the findings and are followed by Chapter 7 which discusses the findings in light of published literature. Finally Chapter 8 discusses the trustworthiness of the research, its limitation and the utility of the findings.

This current Chapter offers the context to this study and describes my motivations for conducting this research.

1.1 Motivation for my research from a personal perspective

I was born and brought up in Israel. I moved to Scotland after completing a two year mandatory service period in the army working as a teacher in a unit responsible for the integration of underprivileged soldiers. That experience gave me my first insight into the importance of multidisciplinary work in providing opportunities within the working environment for recruits to study, to gain new skills and to flourish.

In Scotland, I trained and later worked as a podiatrist in Lanarkshire. Throughout my work I was involved in the teaching of undergraduate podiatrists on clinical placements in my locality. At the time when Local Health Care Co-operatives (LHCCs) were being established, I was heavily involved in working jointly with General Practitioners (GPs), nurses and other Allied Health Professionals (AHPs) as part of the re-structuring of services, health promotion initiatives and clinical governance within my LHCC. During that time I learned to appreciate the complexity of General Practice.

In 1999, whilst working as a podiatrist within Wishaw LHCC, I completed a Masters degree in Public Health. Thereafter, I worked part-time both as a podiatrist with Wishaw LHCC and as a public health practitioner with one of the LHCCs on the south side of Glasgow. The contrast in the way the GPs worked between the two LHCCs was intriguing, particularly in the way they involved others (nurses, AHPs and patients) in setting the priorities for the LHCC and in the development of local services. I realised that different General Practices and indeed different GPs attached varying degrees of importance to collaborative work and that such diverse working relationships affected opportunities for health professionals to develop and learn new skills.

In 2002 I moved to NHS Borders to work at the Public Health Department. My work involved liaison with General Practices on the implementation of Scottish Intercollegiate Guidelines Network (SIGN) guidelines, identifying barriers and resources. During that time, I led on a research project investigating compliance with the three key recommendations of the British Guidelines for the Management of Asthma (Wiener-Ogilvie *et al.* 2007). That project suggested that the implementation of clinical knowledge by health professionals in the context of patient care depended to an extent on a number of characteristics of their work environment: organisation, hierarchy, trust and mutual access to team members (Wiener-Ogilvie *et al.* 2008).

Currently I work as an Associate Advisor for quality assurance and research in NHS Education Scotland in a unit responsible for General Practice Specialty Training (GPST) in South East Scotland Deanery. The unit has overall responsibility for the management of approximately 250 doctors in General Practice training. Much of my work involves conducting focus groups and interviews with GP trainees and their trainers as part of evaluation of educational delivery programmes and of ongoing research at the unit. The Deanery is also required to assess and report on the quality of the training of various educational providers (such as hospital units and General Practices) to the General Medical Council (GMC), based on the training standards provided by the GMC (GMC, 2010; GMC 2011). My job has made me aware of the

role the workplace environment plays in shaping trainees' experiences and the learning opportunities available to them.

Particularly, I became aware of the limits of GMC standards in the quality assessment of the training environment of doctors. The domains outlined by the GMC framework include: management of education delivery, equality, diversity and opportunity, recruitment, selection, and support and development of trainee and trainer. These domains often focus on the more easily measured aspects of training such as programme management, protected formal teaching, study leave, compliance with the European Working Time Directive, formal supervision arrangements and formal induction. In addition, the evidence underpinning the development of the standards is not clearly outlined. The standards were originally developed by the Postgraduate Medical Education Training Board (PMETB 2005) which has since merged with the GMC. At the time, the PMETB stated that the standards were developed through agreement between committee members on what was thought to be important for training but there was no clear linkage with published medical education research.

These issues have further stimulated my interest in the way the training environment of doctors shapes opportunities to learn. I began to question whether what the regulator required Deaneries to measure were indeed aspects of the training environment important for trainee doctors. In particular, I became interested in the relationship between the training environment and preparedness for practice. Were certain characteristics of the environment better than others in preparing trainees for work?

Recently, in a submission to the United Kingdom (UK) parliament, the Royal College of General Practitioners (RCGP) proposed an increase in the time trainees spend in General Practice from 18 months to two years, in line with other European countries. I was aware of discussions about the extension prior to conducting this thesis. The shift in the balance of General Practice training away from the hospital environment highlights the importance of understanding the training environment in

General Practice. I felt, therefore, that a study investigating the relationship between the General Practice training environment and preparedness for practice could be particularly useful in informing such discussions.

The purpose of this study is to explore trainees' and early career GPs' descriptions of their training environment in General Practices and to gain some understanding of the way the training environment affects preparedness. Significant financial resources are allocated to General Practice training in order that trainees should be ready to function as General Practitioners on completion of the programme. There is, therefore, a need to gain a better understanding of the relationships between the training environment and preparedness.

1.2 Context: General Practice and General Practice training

This section presents the contextual background to the research reported in this thesis. It provides an overview of the scope of General Practice in the UK in order to outline the roles and responsibilities trainees are expected to undertake on completion of their training. The section also describes developments and changes in General Practice training in the UK, including changes to curriculum and assessment, and outline the current system of General Practice training. The role of the GP trainer, the training Practice and the format of training within the Practice are all considered.

1.2.1 General Practice and the role of a General Practitioner

Despite General Practice being at the core of primary care services, there is no clear definition of it in the literature. The role of the GP was established with the formation of the NHS in 1948. GPs were given the responsibility of looking after the entire population and of controlling access to speciality services. At the time, GPs chose to remain outside the Health service and work as independent contractors mainly in single-handed Practices. The trend to form group Practices started in the

1960s, with GP partnerships being the norm nowadays. Their obligations have been thus defined: *“To render to their patients all necessary and appropriate medical services of the type usually provided by General Practitioners”* (BMA 1965; Department of Health 1989).

The Royal College of General Practitioners provided a more comprehensive picture of the knowledge, skills and attributes considered essential for General Practice by defining a GP as a doctor who deals with patients in terms of their physical, social and mental well-being (RCGP 1985). Olesen (2000) suggested a definition of a GP that also takes account of the context in which the GP works and of the relevant social responsibilities:

“The general practitioner is a specialist trained to work in the front line of a healthcare system and to take the initial steps to provide care for any health problem(s) that patients may have. The general practitioner takes care of individuals in a society, irrespective of the patient's type of disease or other personal and social characteristics, and organises the resources available in the healthcare system to the best advantage of the patients. The general practitioner engages with autonomous individuals across the fields of prevention, diagnosis, cure, care, and palliation, using and integrating the sciences of biomedicine, medical psychology, and medical sociology.”(p.355)

Contact with the patient in the social context is defined as being at the core of General Practice. A report by the Kings Fund (2011) emphasises this. It suggests that General Practice maintains a fundamental commitment to centralism which manifests itself in two elements: patient centredness and holism. Patient centredness means that patients' individual priorities are identified and respected, with services organised on the basis of these needs. Holism refers to a system of care where decisions, made on the diagnosis and management of a patient, reflect the entirety of that person's needs. More recently, the RCGP and the Heath Foundation commissioned a report on 'generalism' (Finaly 2011) which emphasised that the medical generalist should concentrate on wellbeing, the primary focus being the patient not the illness.

In the UK, General Practice is the first point of contact with health care services for the majority of people. Recent Scottish workforce data suggest that contacts with a GP account for most encounters with primary care services, with an increasing number of patients contacting General Practice services. Although there has been an increase in the number of GPs working in the Scottish NHS over the past decade, their working patterns have changed with more of them working less than full time. Table 1 summarises some key data in relation to General Practice workforce.

Table 1: General Practice Workforce data (ISD 2009; ISD2012)

<ul style="list-style-type: none"> Between 2002 and 2012 the number of GPs working in Scotland has increased by 9%.
<ul style="list-style-type: none"> The number of salaried GPs increased by 13% .
<ul style="list-style-type: none"> Individual GPs were working an average of 7.2 sessions a week. About 33% of GPs worked less than full time (between 5-7 sessions a week)
<ul style="list-style-type: none"> Estimated number of people contacting General Practice Service has risen from 15.618 million (CI 14.922-16.314) during 2003-4 to 16.539 (CI 15.800 - 17.278) in 2009. Consultations with GPs accounted for two thirds of consultations in primary care.
<ul style="list-style-type: none"> The average size of a Scottish General Practice in terms of the number of registered patients is 5,586.

The scope and range of activities of General Practice have developed over the years, shaped by contractual changes. The most recent contract introduced in 2003 (BMA 2003) has increased funding to General Practices and provided financial remuneration for activities and services with increased accountability for the quality of care. General Practices now offer a range of services including screening, immunisation and health promotion, and preventative care. In addition, much of chronic disease management is now undertaken in General Practice with a growing number of hospital services being delivered in General Practice in an attempt to bring services closer to patients (Scottish Government 2010). Management of patients in primary Care has become increasingly complex as nearly a quarter of patients are multimorbid, suffering from two or more disorders (Barnett *et al.* 2012). The increase in ageing population and advances in the management of medical care, have also increased complexity of care and the need to work across professional medical

disciplines. GPs are therefore expected to manage more complex clinical issues and a broader range of services with support from the extended primary health care team (nurses and AHPs).

To support such extensive work nowadays, General Practices often comprise GP partners, employed GPs, employed practice nurses and health care assistants as well as an extensive administrative team. In addition, Practices often host a number of practitioners such as community nurses, district nurses, midwives and allied health professionals, who are employed by NHS organisations external to the Practice. The shift towards preventative care and the need to demonstrate the quality of care delivered by General Practice bring added responsibilities for GPs. The role of the GP has therefore evolved beyond the one-to-one clinical care of patients as GPs now engage in managerial and leadership roles as well as clinical duties. Furthermore, the Department of Health White paper *Equality and Excellence: Liberating the NHS* (2010) outlined plans for General Practices to commission most of the services needed by their patients. This further emphasises the managerial responsibilities that GPs are expected to undertake. Consequently, Gerada, Riley and Simon. (2012) argued that GPs require enhanced clinical, generalist and leadership skills.

1.2.2 General Practice training

The development of General Practice training programmes in the UK

Training requirements for General Practice Specialty were stipulated by statute in 1979 (NHS VT Regs 1979). General Practice training was first introduced as a legal requirement for GP principals in 1981. To become a GP, a doctor had to complete a minimum of two years in educationally approved hospital posts, in a variety of specialities, and a minimum of one year in General Practice as a General Practice Registrar.

In 1997, the Vocational Training Regulations were further amended to require all doctors training in General Practice to complete a 'summative assessment' prior to certification. The summative assessment consisted of a series of recorded consultations with patients and an audit of clinical practice, both marked by RCGP examiners, as well as a GP Trainer's Confidential Report. In addition, doctors had to pass a knowledge questionnaire. Passing the summative assessment entitled doctors to become registered GPs but RCGP membership was obtained through a separate examination system, and remained optional.

Launched in 2003, the Modernising Medical Career (MMC) Programme brought about major changes to postgraduate medical training. MMC was intended to create a transparent and efficient career path for doctors in the UK as there were concerns that many hospital doctors at Senior House Officer level, had no clear career pathways or defined educational goals and saw no distinction between service and training in their jobs (Department of Health 2004a). MMC principles stated that Specialty Training should be programme-based, designed to deliver nationally agreed standards and to review the progression of trainees on an annual basis. Satisfactory completion of training should be marked by entry in a register. There followed the development of training standards under the auspices of the Postgraduate Medical Education and Training Board (PMETB 2005), later replaced by the General Medical Council (GMC) training standards (GMC 2010; GMC 2011).

Since 2005, medical school graduates enter an initial two-year period of basic training known as a 'Foundation Programme', which normally consists of four-month placements in a wide range of specialties. On completion of this programme, doctors can apply for one of a number of Specialty Training Programmes, including General Practice (Ahluwalia and Swanwick 2008). General Practice training programmes usually run for three years (although four-year programmes have been available in Scotland since 2010). Each individual programme offers trainees a broad and balanced variety of working placements approved by the GMC. From August 2008, the length of time General Practice specialist trainees are required to spend in General Practice as part of their training was increased from 12 to 18 months with

the rest of the time spent in relevant hospital-based placements. In Scotland trainees normally spend six months in a General Practice during the first or second year of their training, with an additional 12 months spent in General Practice as the last year of the programme.

In 2007, following the changes introduced by MMC, the RCGP introduced a single training and assessment system for UK doctors wishing to obtain a Certificate of Completion of Training (CCT) in General Practice and to practice as GPs in the UK (Riley 2009). As distinct from the previous system, completion of training qualifies doctors to become members of the RCGP. A new training curriculum and assessment system were established. The New Membership of the Royal College of General Practitioners (nMRCGP) replaced the previous summative assessment.

The nMRCGP is an integrated assessment incorporating three components (RCGP 2013). These are outlined in Box1:

Box 1: nMRCGP assessment

1. ***Applied Knowledge Test (AKT)***: a multiple-choice style assessment of the application of knowledge.
2. ***Clinical Skills Assessment (CSA)***: an OSCE (Objective Structured Clinical Examination) type exam of simulated consultations with patients, designed to assess doctor's ability to integrate and apply clinical, professional, communication and practical skills appropriate for General Practice.
3. ***Workplace-Based Assessment (WPBA)***: a three-year ongoing evaluation of a doctor's progress and performance tested in the workplace by supervisors. Evidence for WPBA is collected in an electronic portfolio (e-portfolio) for each GP trainee.

A CCT in General Practice is awarded at the end of the training period only to those doctors who complete their approved training posts and succeed in passing all three components of the nMRCGP assessment.

The new RCGP curriculum

The RCGP introduced a new competence based curriculum to guide training. The concept of the competency-based curriculum is underpinned by the notion that occupational roles can be analysed and broken down into attainable outcomes and measurable progress as targets for trainees (Leung and Diwakar 2002). Based on an extensive literature review Epstein and Hundert (2002) defined competence as '*the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served*'(p.226). A similar definition was used by Björkström *et al.* (2008) to describe competence of trainee nurses.

Miller (1990) suggested a model for performance and competence which included four stages: 'Know'- acquiring knowledge, 'Know how'- knowing how to use it, 'Show how'- demonstrating the skill, and 'Does'- applying the skill in practice. However, both the performance and competence model and its offshoot, the competence-based curriculum model, have been widely criticized. For example, Grant (2003) suggested that competencies alone cannot describe the skills of the profession and that the achievement of competencies does not necessarily translate into performance. In addition, Rethans *et al.* (2002) argued that several studies showed differences between what doctors do in controlled critical situations and what they do in actual practice. Therefore they suggested that achieving competencies in training does not necessarily translate into actual work practices.

The new RCGP curriculum, which was introduced in 2007, revised in 2009 and again in 2012, is competency-based around the core statement *Being a General Practitioner* (RCGP 2007). It covers the key elements of knowledge, skills and aptitudes that every GP is expected to master. The 2007 curriculum sets out six areas of competence and three essential applications characterising General Practice as a Specialty. The leadership element was developed in the 2012 (Riley, Haynes, and Field 2012). Box 2 (p.13) describes the main competence areas and applications:

Box 2: Competence areas and applications

1. **Primary care management** (management of contact with patients)
2. **Person-centred care** (understanding patients as individuals and working in partnership with them)
3. **Specific General Practice problem-solving skills** (skills for managing uncertainty and risk)
4. **A comprehensive approach** (management of multiple morbidities, co-ordinating care and health promotion)
5. **Community orientation** (understanding the interrelationship between health and social care, and the tensions between what the individual wants and needs)
6. **Holistic approach** (understanding values, culture and beliefs and how these affect the management of patients)
7. **Essential Application Feature 1** -Contextual aspects of care (how aspects of the environment in which one works can influence the quality of care)
8. **Essential Application Feature 2** -Attitudinal aspects of care (own professional values and ethics)
9. **Essential Application Feature 3** -Scientific aspects of care (evidence based approach to practice)

Local arrangements for the management and delivery of General Practice training

In most UK Deaneries, General Practice Specialty training is delivered through a School of Postgraduate General Practice Education. A Director of Postgraduate General Practice Education manages a network of GP trainers to develop and deliver programmes. Local management structures vary considerably across the UK (Ahluwalia and Swanwick 2008). Local programme directors are responsible for designing and maintaining programmes and for allocating trainees to hospital and General Practice posts (placements). Deaneries offer a variety of courses and other educational opportunities to meet the needs of learners and of RCGP curriculum requirements.

Each trainee has a nominated GP educational supervisor throughout training. The supervisor is responsible for monitoring the progress of the trainee through an e-portfolio and WPBA. In Scotland the educational supervisor is a GP trainer. When trainees undertake hospital placements, they have in addition a clinical supervisor who is responsible for overseeing their day-to-day work. When a trainee is working in General Practice, it is common for both of these roles (educational and clinical

supervision) to be taken on by the GP trainer. With the extension of the General Practice component from 12 to 18 months, trainees can now train in two separate General Practices although only one of the GP trainers will normally act as educational supervisor.

The evidence amassed in the e-portfolio, including the Workplace-Based Assessment, is reviewed at six-month intervals by the educational supervisor and annually by a local expert Deanery panel (Annual Review of Competence and Performance panel). A final judgment of competence to practice independently as a GP is made towards the end of training.

The GP trainer

In Scotland, to become a trainer, a GP has to undertake the Scottish Prospective Education Supervisor Course (SPESC) and the General Practice in question has to be approved by the Deanery as an educational provider of General Practice training. Approval of both trainers and Practices is on a three-year cycle, with the Practice and the trainers having to demonstrate that they are meeting GMC standards for training (GMC 2011). In reality, trainers and training Practices are rarely de-selected. Nevertheless, trainers have to demonstrate commitment to training and to development of their skills as trainers, normally through attendance at courses or through involvement in trainer networks in their area.

The nMRCGP brought changes to the GP trainer's role. Where previously the role primarily involved mentoring and support, the new process added the function of assessor to that of trainer. The consequent potential to affect the trainee-trainer relationship was initially a concern to some trainers (Wiener-Ogilvie, Jack, and Lough 2008).

Training Practices

In Scotland, training Practices are General Practice surgeries approved as such by the local Deanery. There is normally at least one trainer in the Practice but in larger Practices there can be two or more. A training Practice usually includes GPs, a manager, and administrative and nursing staff (Practice and treatment nurses). There is often other attached staff, such as health visitors, district and community psychiatric nurses, and providers of other visiting specialist services.

There are two types of General Practices in Scotland, namely, Primary Medical Services (PMS) and General Medical Services (GMS) Practices. In PMS practices, GPs, administrative and nursing teams are all employed by the local health boards, however very few practices are PMS practices. GMS practices (majority of practices in Scotland) are partnership Practices, where GPs work as self-employed professionals in partnership with one another. General Medical Services Practices are contracted by a Primary Care Trust to provide their services, the GPs being responsible for the employment of their staff, the development of services and the generation of income. Income in such Practices is generated through the General Medical Services (GMS) contract, which provides a global sum and financial incentives, both for high quality care, measured through a Quality and Outcomes Framework (QOF) system, and for enhanced services (NHS Employers 2013). Partners receive an income depending on profit share (King's Fund 2009). Both type of Practices are eligible to apply to become training Practices.

In Scotland, trainees attached to a General Practice are typically expected to work seven clinical sessions, with in addition three educational sessions, each week. A clinical session, approximately four hours long, comprises face-to-face appointments with patients, telephone consultations, home visits, formal Practice meetings, and administrative clinical tasks such as checking test results, reading correspondence, making referrals and dictating letters. The number of patients seen and the length of time spent with each one by the trainee depend on experience. Thus, a trainee in the first year of General Practice training may begin by spending 20-30 minutes with each patient, reducing to 15 minutes by the end of a six-month placement. Trainees

are expected to reduce appointment times, without detriment to quality of care, with the aim of consulting at ten-minute intervals by the end of their training. Trainees also normally spend some time with the extended primary health care team learning about their different roles. They are further required to undertake 72 hours of out-of-hours work during the course of the year. The three educational sessions are divided between private study, formal teaching with trainer or other clinicians, and educational meetings with other trainees facilitated by a trainer (half day release - HDR).

Practices do not employ their trainees whose salaries are paid by the Scottish Deaneries (NHS Education Scotland). Practices receive a training grant to cover the cost of providing education for the trainee(s) attached to the Practice, and trainers receive an annual grant from the Deanery to assist them in the professional development of their training roles. Training Practices thus benefit from the services provided by trainees although the burdens of WPBA and educational supervision mean that trainers have to allocate time in their working week for training in addition to or instead of their other responsibilities.

1.3 Summary

In summary, the motivation for conducting this research was my interest in the training environment of GP trainees and my involvement in quality management of General Practice training. The research presented in this thesis describes the training environment in General Practice and aims to improve understanding of the way the training environment can affect preparedness. Understanding this issue is important in view of the changes introduced to General Practice training, particularly the extension in the time GP trainees spend in General Practices during training.

Chapter 2: Literature Review- workplace learning, professional development and preparedness

This Chapter provides a structured review of the theoretical background to my research for this thesis, pinpointing the main findings which arise from the literature. The review aims, while identifying any relevant gaps, to explain how the literature has guided the development of the research questions delineated in Chapter 3.

The review begins with a description of my approach for conducting the literature review, followed by separate sections concerning three main literature review areas:

- Workplace learning
- Professional development
- Preparedness

2.1 Approach to conducting the literature review

In conducting my review, I followed the approach advocated by Eva (2008), specifically, to present a synthesis of a variety of contributions, identifying well-established knowledge and common issues while highlighting gaps in understanding and areas yet to be considered.

The research purpose has guided the literature review, namely, to explore the way GP trainees describe their training environment in General Practices and the way they perceive that environment to impact on their preparedness. As the training environment is also the working environment, I first sought to explore the literature on workplace learning. In addition, I researched literature concerning the professional development of doctors, including the areas of knowledge and identity, issues likely to enhance the understanding of preparedness. Finally, I reviewed medical education literature in relation to preparedness.

Research strategy

My search focused on peer-reviewed journals and books. Additionally, publications by professional bodies were identified through conversations with colleagues and other researchers, as well as through references in peer-reviewed papers. Although the primary focus was on research published in medical education literature, I expanded my review to include other contexts such as teacher education and human resources. The following databases were used to research literature published between 1996-2012, the relevant subject headings and key words being outlined in Box 3:

- Medline – US National Library of Medicines® (NLM)
- Embase- medical answers Elsevier
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- Educational Research Index (ERIC)

Box 3: Subject headings and keywords used in each database search

Database	Medline , Embase and CINAHL	ERIC
Combinations of key words used	<p><u>Group A keywords:</u> Medical students Doctors Physicians Trainees Internship Residency General Practice Family doctors Family physicians</p> <p>Combined with one of the following keywords (group B): Workplace Workplace learning Educational climate Training environment Workplace environment Work environment Preparedness Transition Professionalism</p>	Workplace Workplace learning Educational climate Training environment Workplace environment Work environment Preparedness Transition

The Edinburgh University book catalogue was searched using the following terms: ‘workplace learning’, ‘educational climate’, ‘training environment’, ‘workplace environment’, ‘work environment’, ‘preparedness’ and ‘professionalism in medicine’.

I also undertook a second-stage literature search, employing a strategy which included the following elements:

- ‘Snowballing’, where the references of relevant papers were searched to identify additional relevant literature.
- Manual searching of the literature on workplace learning or preparedness published between 2009-2012 in four key peer-reviewed journals: ‘Medical Education’, ‘Academic Medicine’, ‘BMC Medical Education’ and ‘Education for Primary Care’.
- Edinburgh University’s electronic Searcher engine was used to identify theses, dissertations and reports using the keyword matrix outlined in Box 3.
- The initial database search identified additional key words which I felt were relevant to my literature review. These included: ‘community of practice’, ‘situated learning’, ‘supervision’ and ‘professional identity’. ‘Community of practice’ and ‘situated learning’ were then used as additional key words in searching all databases (Medline, Embase, CINAHL and ERIC). The terms ‘supervision’ and ‘professional identity’, combined with Group A keywords, were used in searching Medline and Embase as I was particularly interested in the literature relating to doctors.

Limitations of the research strategy

Although the database search identified studies published in several languages, my review was restricted to those in English as well as to the small number in Hebrew. While my primary database search was limited to literature published between 1996-2012, the second-stage search resulted in some earlier literature being reviewed as well.

In addition, I compared literature with supervisors, colleagues and fellow researchers. All this enhanced the comprehensive nature of the review and ensured that key papers were not overlooked.

I believe my approach identified most of the literature relevant to workplace learning, medical professionalism and preparedness. My strategy was reinforced by access to both NHS Scotland Knowledge Network and Edinburgh University Library databases. This enabled me to refer to a large number of full-text journals. In addition, I was able to obtain papers, not available electronically, through the NHS Health Management Library. My approach may, however, have excluded some relevant older or foreign language studies. A number of possibly relevant German and Spanish papers were not included. Because the databases used capture primarily medical and teachers' education literature, the review did not include work published in other professional disciplines (for example, law and engineering).

2.2 Workplace learning—theoretical background

The topic of workplace learning has attracted growing interest since the 1980s due to the increased rate of changing technologies, and to the modernisation of public services (Illeris 2004; Boud and Garrick 1999). These developments have resulted in what Illeris called a “knowledge society”, one in which working conditions can change radically during a single lifetime. The role of the work environment and its effect upon learning opportunities, have therefore become the subject of social and educational research.

Postgraduate Medical Training differs from undergraduate programmes as the majority of the learning occurs whilst doctors are working. The workplace, to a large extent, determines the training environment. Accordingly, my literature review outlines a number of theoretical perspectives on learning at the workplace.

Psychological theories on learning, relevant to the workplace emerge from a variety of schools of thought – the behaviourist, the cognitive and the social. Behaviourist principles are applied in skill-based teaching while cognitive models have dominated medical education for many years. More recently social models have emerged in the context of workplace learning and medical education. The following sub-sections provide descriptions of these different approaches, their application to medical education and their relationship to workplace learning. Humanistic theories of learning, the terms ‘informal’, ‘non-formal’ and ‘incidental learning’ are also briefly discussed and some theoretical models on learning in the workplace are outlined. The final section refers to research on the way the workplace environment affects opportunities to learn. Research findings from medical education literature are reported.

Behaviourist perspective of learning

The main influences on this perspective were psychologists Ivan Pavlov (1927), who investigated classical conditioning, Burrhus Frederic Skinner (1938) and John Watson (1950). Behavioural psychology focuses on the effect and consequences of doing something and the subsequent repetition of that behaviour.

The assumption of behaviourism is that learning is manifested through changes in behaviour, such changes being responses to external stimuli. Behaviourists argue that simple associations are the building blocks for all learning. They concentrate upon learning by doing in a variety of contexts, with reinforcement or reward as the prime motivator.

According to this approach workplace learning is enhanced when the workplace offers opportunities for learners to undertake tasks, for example, when medical students do clinical work during their placements as opposed simply to observing others doing the work. Having clear objectives also assists learning. In medical education behaviourist models are applied in skill-based teaching, such as the acquisition of surgical skills (Hartley 1998), but are less helpful in explaining other aspects of learning, for example, the forming of professional judgements or identities.

Cognitive perspective of learning

Traditionally learning belongs in the field of cognitive psychology which views it as an inherent psychological process whereby an individual acquires knowledge, skills, attitudes and opinions. From a cognitive perspective, knowledge and skills are produced through a process of transmission from a more able 'other' or through engagement with one's own experiences (constructivism). Learning takes place through the combination of newly received impressions with information previously stored as patterns or 'schemes'. Cognitive literature emphasises that learning occurs through problem solving alerting an internal processes within individuals.

Constructivism is closely linked with the work of Jean Piaget (1976) who takes the position that meaning (or learning) is generated through engagement with the experience. He suggests that, since individuals seek to maintain equilibrium in their encounters with everyday life, they attempt to balance prior knowledge with current experience. Equilibrium is preserved through the process of 'assimilation' and 'accommodation', where 'assimilation' uses existing knowledge to respond to a task and 'accommodation' develops fresh knowledge when a new situation arises. Learners construct their own knowledge by interpreting information in light of existing understanding and abilities. The limitation of the cognitive approach is that it presents learning as an internal, virtually unmediated process, where environmental factors and their effect on learning are less important.

Reflective and experimental models of learning such as those suggested in the work of Dewey (1933) and Kolb (1984) highlight the importance of reflection. Dewey suggested that individuals use reflective thinking as a response to real world problems and dilemmas they encounter. Kolb saw learning as a process whereby knowledge is created through the transformation of experiences, which involves a continual process of experience and adaptation to the world. Schön's (1983) theory of reflective practice suggests a way in which the environment can facilitate cognitive learning processes. He proposed that reflection functions as a mediator between existing knowledge and skills and new observations and experiences,

thereby being an important facilitator for learning. Schön describes as ‘reflection in action’ the process by which a person draws on experience to identify a problem, to suggest appropriate action and to reinterpret the situation in light of the consequences. ‘Reflection-on-action’ describes the influence of retroactive thinking on later practice.

It is claimed that opportunities to engage in problem-solving at the workplace are important for learning as they facilitate reflection. Slotnick (1996) suggested that medical trainees’ reflections in response to complex and new problems helped learning. Sargeant *et al.* (2006) showed that reflection was common among doctors rated highly by colleagues and patients. Similarly, in a study on managers in the workplace, Marsick and Watkins (1990) established that learning was enhanced when individuals were given time to think through their impulse reactions.

In postgraduate medical education, approaches to learning which focus on a cognitive approaches and reflective practice, have shaped the development of the appraisal system of doctors, the use of personal development plans and the use of instructional methods for teaching (Swanwick 2005).

Social theories on learning

The post-industrial era brought change to the nature and requirements of the workplace. The emphasis was not longer on technical skills but rather on the ability of a worker to analyse a situation, determine the nature of a problem and devise solutions. The focus moved from purely behavioural models of learning concentrating on the acquisition of technical skills to the development of social theories on learning (Marsick 1987).

Social cognitive approach to learning

The social cognitive approach combines two perspectives on learning, namely, the behaviourist, which emphasises environmental influences on people’s actions, and the cognitive, which emphasises cognitive processes of learning.

Albert Bandura (1986) suggested that learning is a result of the dynamic among three sets of determinants - personal, environmental and behavioural. He claimed that there are five capabilities which underpin learning – the ability to transfer experiences into symbols that serve as guides for future actions (symbolising capability), the ability to plan future actions and anticipate outcomes (forethought capability), the ability to learn by observing other people (vicarious capability), the ability to self-regulate by applying internal standards (self-regulatory capability) and the ability to reflect on experiences (reflective capability).

Bandura's theory on modelling (1977) can also be used to describe the process of 'tacit learning', a concept originating with Hungarian-born philosopher Michael Polanyi (1966) who suggested that humans can acquire knowledge through experience rather than verbally. Tacit learning, according to Bandura, occurs unconsciously through observing others and assimilating what they say or do. When they observe others, learners absorb and symbolically code information which they can store, recognize cognitively and retrieve. They then rehearse actions and modify their behaviour in line with the feedback they receive.

Tacit learning is also relevant in the context of medical education. Epstein (1999), in his description of the 'mindful practitioner', suggests that elements of medical practice are learned tacitly through observation and actual clinical work. Similarly, Cruess, Cruess and Steinert (2008) propose that in medicine role models function as part of the "informal and hidden curriculum", with medical students learning from their own experience and by observing the actions of others. Learning from role models relates not only to practical skills but also to attitudes, behaviour and professional values. Such learning involves the transmission of normative rules regarding behaviours, values, attitudes and beliefs which reflect the 'hidden curriculum' of that particular workplace (Hafferty and Franks 1994; Chuang *et al.* 2010).

Social constructivism

The central premise of social constructivism is that, because knowledge resides within cultures, learners make sense of new ideas and information through social engagement. Lev Vygotsky (1978), a key proponent of social constructivism introduced the need to match the learning approach to the learner's development stage through the construct of the *zone of proximal development* which refers to what a learner can learn with the support from a more knowledgeable 'other'. In this model, co-workers play a significant role in learning through participation in problem-solving shared between the novice and the experienced worker. Vygotsky referred to such problem-solving as proximal guidance. Practice Based Small Group Learning (PBSGL), employed in continuing professional development of General Practitioners in Scotland and Canada, is an example of how the approach of shared problem solving is applied in medical education.

Mezirow (1994) developed the concept of 'transformative learning', defined as a social process of constructing and internalising a new or revised interpretation of experience as a guide to action. He distinguished three domains: instrumental learning – task-orientated problem-solving; dialogic learning – understanding the norms and the culture of an organisation; and self-reflective learning - understanding by critically reflecting on oneself as part of a social unit. Personal insight is shaped through social interaction and is therefore affected by the beliefs and values of others.

Social constructivist models are also used to explain the development of professional identity by doctors and to emphasise the role of language in defining that identity. Newcomers to the workplace learn not only *from talk* but also *to talk*, adopting the local symbols (Swanwick 2005; Rees and Monrouxe 2010; Monrouxe 2010).

According to Mezirow, ideal learning conditions in the workplace promote a sense of safety and trust and encourage employees to participate in decision-making, to review perspectives, attitudes and roles, to think critically and reflectively, to

question what is taken for granted and to experiment, all without suffering adverse consequences (Marsick 1987; Taylor 1998).

Socio-cultural theory

Socio-cultural theory of learning relates to the 'situated learning theory' proposed by Lave and Wenger (1991). The theory assumes that learning is an integral part of social practice and of identity construction. Its central tenet is that learning occurs through social interaction, shaped by context and by historical and cultural influences. The focus is shifted away from the individual learner to 'team' or 'community' learning. The theory suggests that in order for learners to understand work based practices, they need to have a sense of the history of those practices and how they have evolved over time. Learning emerges through opportunities to participate in professional practice and entails the development of both the skills and the identity of that professional community.

Lave and Wenger based their theory, known also as 'community of practice', upon ethnographic studies of traditional apprenticeships. Situated learning arises through collaboration with other learners and with more senior community members in carrying out activities related to the practice of that community. Learning is not something undertaken to become a member but rather is an evolving form of membership in a community of practice such as a workplace, a profession or any other social group with particular purpose or activities.

Lave and Wenger suggest that new learners enter the community of social practice and learn through a process of legitimate peripheral participation in which they perform the less vital tasks of the community. The term 'legitimate' indicates that the learner has been accepted into the process of becoming a full member. As they take on more responsibility, learners move towards the centre of the community and become less peripheral. With increased participation they negotiate meanings and come to understand knowledge particular to that community. Central to this theory is that learning is part of social practice, with communities of practice being defined by their shared expertise. Relationships between 'newcomers' and 'old timers' differ from the hierarchical model of 'novice' to 'expert'. Situated learning values the

contribution of newcomers to the development of practice as with time newcomers themselves can shape the values and practices of their community. In later work Wenger (1998) described different types of opposing dynamics that can exist in communities of practice which he referred to as 'dualities' that can be either creative or restrictive to the development of the community.

Wenger (1998) suggested that four components are present in a community of practice: *meaning*- learners talk about their experience and create shared meaning; *practice*- learning as doing where members talk about shared ideas and resources in support of their actions; *community*- learning as belonging, where members' talk about community processes and are developing competence; and *identity*- learning as becoming, where members' talk about how learning changes who they are.

Situated learning is closely connected to the notion of 'informal learning' (see section 2.2.4). In keeping with constructivism, it views learning as a process of active participation in problem-solving and critical thinking, where knowledge and understanding are constructed through engagement. The Lave and Wenger theory of 'situated learning' is supported by other workplace learning studies. For example, Fuller and Unwin (2003) found that workplaces with successful apprenticeship schemes had allowed apprentices to participate in multiple communities of practice. Such working environments, by explicitly recognising the apprentice's status as a learner, had legitimised peripheral participation.

Situated learning theory has been criticized for its lack of attention to the way the characteristics of the workplace affect access to learning (Billett 2002). It is also argued that the theory describes the learner as passive and does not take into account the choice the learner makes about the extent of participation (Kennedy *et al.* 2009a). Others have suggested that cognitive and social theories on learning are not mutually exclusive but rather that both perspectives are needed in order to understand how learning occurs (Sfard 1998; Lonka 2009).

Billett (1996), reflecting on both cognitive and socio-cultural approaches to learning, argued that the two are interlinked. He suggested that 'cognitive structures', which are taken to be the internal product of memory, are constructed and developed in particular social circumstances. He illustrated the commonalities between the two

perspectives, suggesting that both recognise the importance of context in the development of expert knowledge and that in both learning is derived from problem-solving. He proposed that the relationship between individual cognitive structures (prior and developing knowledge) and social circumstances (cultural norms and values) during problem-solving will determine how knowledge is acquired.

Billett's linkage between the cognitive and social aspects of learning was highlighted in his studies of coal miners and of workers in other industries. He showed that effective learning resulted from engagement in 'authentic activities', guided by experts and through interaction with other learners. Although construction of understanding was unique to the individual, it was shaped by workplace culture and practice. His findings suggested that the workplace facilitated learning in a number of ways: 1) authentic goal-directed activities, 2) access to guidance - both close assistance from experts and distant observing of and listening to other workers, 3) everyday engagement in problem-solving which leads to indexing, and 4) intrinsic reinforcement (Kerka 1997).

Later Billett (2009) refined his theoretical framework on workplace learning and suggested that the learning experience is derived through the interaction between the social world of the workplace environment and personal world of the individual. He suggested that the way individuals cognitively engage with their workplace norms and values is shaped by their 'personal agencies' that is their personal history, personality, intentions and values. Learning experiences are therefore a result of the negotiation between the social world and the individual interpretation of this social world. It is through these negotiations that the individual learns the norms of their workplace. Individual engagement with the workplace, according to Billett and Smith (2006) is therefore mediated by their personal agency (their intention to participate, and construction of meaning and values).

Humanistic theories of learning, non-formal, informal and incidental learning

Humanistic models of learning, such as those suggested by Maslow (1970), Rogers and Freiberg (1994) and Knowles (1984) focus on self transformation and self development. Their underlying assumption is that individuals have an intrinsic drive for self-development. For example, Maslow described a hierarchical model in which the physical, emotional and psychological needs of the learner need to be met before effective learning can take place (Monkhouse 2010). Central to Knowles theory is the premise that adults need to know the reason for learning with relevant experience being the basis and driver for their learning. Knowles viewed learning as an internal process for individuals and in its social context, resulting from contact amongst individuals (Marsick 1990). Knowles theory is illustrated by Sargeant (2006) in a study on how family physicians learn which showed that dealing with patients and the problems they presented stimulated doctors to learn more and to address knowledge gaps identified through encounters with patients.

Knowles also contributed to the literature on self directed learning together with Tough (1979). This literature implies that people accept responsibility for their learning and are pro-active in pursuing it. Respect for the autonomy of learners is therefore an important facilitator for learning according to this literature.

Eraut (2000a; 2000b) used the term ‘non-formal’ learning to focus on the intention to learn. He described three types of learning: *implicit learning*, characterised by learning without prior intention to learn, the learner being unaware of the learning at the time; *deliberate learning*, where the learning is planned and purposeful; and *reactive learning*, which happens spontaneously and is unplanned but with the learner recognising the learning opportunities and reflecting upon events or experiences.

‘Informal’ or ‘incidental’ learning are alternative terms used in the literature to describe non-formal learning at the workplace. Billett (2001a) suggested that informal learning is sometimes unplanned and results from spontaneous opportunities. He called such opportunities, which arise from corridors conversations or through observing others, ‘unintended forms of co-participation’. Having studied

apprentices in various occupations, Billett (2001b) suggested that informal learning can be structured and have transferable outcomes. Similarly, Lave (2011) described how learning in the tailoring profession involved progression through tasks that involved different levels of accountability. Learners had access to 'models of performance' as well as to direct and indirect (by observation) guidance. These observations suggest that even informal learning can be structured and legitimate.

Alternatively, Marsick and Watkins (1990) used the term 'incidental' to define learning which is unintended and where knowledge and skills are gained as a consequence of accomplishing tasks. Learning from mistakes, by doing, through networks or through interaction are all types of incidental learning. Marsick and Watkins argued that although the incidental and informal overlap, they are not the same as incidental learning is the by-product of other activities and is never planned.

Illeris (2004) proposed that the character of the working environment can affect the opportunities for incidental learning. He suggested that the most significant factors affecting such opportunities are variations in the possibilities for employees to make decisions, to be involved in the planning and implementation of new developments, to interact with others, to apply their qualifications, and to have access to and the ability to use information technology.

Theoretical models for learning in the workplace

The concept of work-based or workplace learning was initially developed in the U.S.A. A number of theoretical models were suggested drawing on the behavioural, cognitive and social perspectives described above. Marsick and Watkins (1990), leading American sociologists in the field, described how learning can be aided by improvements in the workplace environment. Their approach, influenced by the theories of Abraham Maslow and Carl Rogers, suggested that learning can occur at individual, group, organisational and professional levels. Since then research on learning at work emerged both from education and management research (Boud and Garrick 1999)

Illeris (2004), a Danish sociologist, proposed a model for workplace learning which suggests that learning takes place on both social (environmental) and individual (cognitive) levels. Cognitive processes, psychodynamic elements (such as feeling and emotions) and the environment are all seen as determinants to the process of learning. Considering both cognitive and social approaches to learning, Illeris described three key dimensions which influence learning:

- *Technical organisational training environment* – work allocation and content, degree of autonomy, use of qualifications, possibilities for social interaction, and strains and stresses.
- *Social training environment* - communities at work, cultural communities and political communities.
- *Employee learning process* - the individual's personal qualities, work experience, education and training, social background and attitude to work.

Drawing on his research in a variety of organisations, Illeris (2004) concluded that learning in the workplace is a product of the encounter between the environment (opportunities for learning) and the employee's potential. Fundamental differences between individuals (such as personality, motivation, confidence), different cognitive styles (for example, reflective versus impulsive style), and different strategies can therefore all affect an individual's ability to learn. Illeris suggested that the relationship between the individual and the environment is dynamic. Thus, while a personality that is analytical, socially independent and individualistic is conducive to informal learning at work, the ability to learn can be impeded by lack of social networks for sharing ideas and information. Similarly, Billet (2002) argued that workplace learning depends on the extent to which individuals have the chance to participate in activities and to interact with their co-workers, as well as on the extent to which they choose to avail themselves of such opportunities. Cliques and affiliations (for example, occupational groupings and trades unions), gender, race, language and employment status can all influence the opportunities for employees to participate in learning.

Billett (Billett and Smith 2006; Billett 2009) proposed a theoretical framework to explain the relationship between the workplace and individual engagement. The framework suggests that individual engagement in work is shaped both by the social experience, that is the values, norms and cues of the workplace, and by the individual's 'personal agency'. 'Personal agency' relates to individuals' cognitive construal of their experiences, their intention to engage, and their construction of meanings and values. It is shaped by the individual's personal history and characteristics, for example maturity. Learning according to Billett is therefore derived both from internal process inherent to the individuals and the social circumstances surrounding them. Maurer, Weiss, and Barbeite (2003) echoed these suggestions and argued that a number of employees' characteristics such as attitudes, insights and intentions to participate affected their participation in work activities and consequent learning and skill development.

Finally relating the literature on workplace learning to the healthcare setting, Newton *et al.* (2011), proposed that three elements influence the development of learning in the healthcare workplace: *personal practice*, that is how individuals participate and learn, *social culture of the workplace* which relates to the relationships between workers and how these influence acceptance of learners and consequently the learning opportunities available to them and *workplace environment* which relates to opportunities for informal learning and sharing of knowledge in the workplace.

2.3 Workplace environment and learning-findings from research investigations

Drawing on theoretical perspectives on learning, a number of research studies have illustrated how both social and technical aspects of organisational environment impact on opportunities to learn at the workplace. Fuller and Unwin (2003;2004; 2010) in studies of modern apprenticeships in the UK used the terms 'expansive and restrictive workplace training environments' to categorise organisational circumstances which provide greater or lesser opportunities for learning. They suggested that expansive environments promote participation and are characterised

by a 'participative tradition', with explicit institutional recognition of and support for the status of learners, and with structured support for apprentices. Restrictive environments are recognisable by narrow access to learning, ambivalence towards the status of learners, lack dedicated individual support and restrictive participation. Evans *et al.* (2007), discussing the expansive–restrictive nature of the working environment, suggested that workplaces can be considered on a continuum from expansive to restrictive training environments.

Other studies also investigated the characteristics of the working environments and how they affect opportunities to learn. Studies, particularly those published in the human resources literature, used quantitative methodologies analysing results from employee's surveys. On the other hand studies from the social science field used qualitative approaches such as anthropological methods.

Aspects of organisational environment identified by the literature to promote opportunities for learning in the workplace are summarised below:

- Environments which allow employee to have control over tasks and have a degree of autonomy over their work (Ellström 2001; Holman and Wall 2002; Illeris 2004; Ouweneel *et al.* 2009).
- Availability of complex and varied tasks in the workplace (Ellström 2001).
- Environments which encourage employee's participation in problem solving (Marsick 1987 and Ellström 2001), with bottom up approaches for innovation (Fuller and Unwin 2003).
- Environment characterised by cooperation and teamwork (Marsick 1987 and Kyndt *et al.* 2009) with support from colleagues and seniors (Ouweneel *et al.* 2009).
- Democratic workplaces with shared power and participation in decision making (Marsick 1987; Clarke *et al.* 2005; Kyndt *et al.* 2009).
- Openness and sharing of information with high degree of trust and authentic communication amongst workers (Marsick 1987; Fuller and Unwin 2003; Clarke *et al.* 2005; Kyndt 2009).

- Opportunities for social interaction (Illeris 2004; Kyndt *et al.* 2009) and external professional contacts (Skule 2004; Evans 2006).
- Opportunities for individuals to participate in work activities and access direct guidance from others and indirect guidance by observing others (Billett 2001; Billett 2004).
- Opportunities for feedback and knowledge acquisition, such as team debriefing or peer feedback (Kyndt *et al.* 2009) and rewards for proficiency (Skule 2004).
- Opportunities for experimentation, initiative and risk taking (Marsick 1987).
- Exposure to demands and changing technology (Skule 2004).
- Opportunities for managerial responsibilities (Skule 2004)
- Structured opportunities for reflection (Clarke *et al.* 2005; Evans *et al.* 2007).
- Physical setting was also shown to affect the employee's ability to listen, observe and interact with others (Billett 2004).

Findings from research in medicine

There has been a growing interest in the interaction between the characteristics of the workplace and learning in medical education (Hoff, Pohl and Bartfield 2004). Indeed, a number of studies have investigated the way in which the workplace environment of health care organisations affects opportunities to learn. Both undergraduate learners not employed by healthcare organisations (for example, medical and nursing students) and employed graduate trainee doctors and nurses have been studied. This review focuses on medical students and trainee doctors.

A number of the characteristics of and opportunities within the clinical environment have been identified as affecting learning:

1. Opportunities to participate in clinical work

Dornan *et al.* (2007) identified participation in practice as the core condition for learning in a clinical setting, increasing confidence in medical students. Having

meaningful ‘patient contact’ by being involved in the clinical care of patients was shown by a number of studies in hospital settings to be particularly important for the learning of medical students (Gibbins, McCoubrie, and Forbes 2011; Billings, Curtis, and Engelberg 2009; Brennan *et al.* 2010; Illing *et al.* 2008; Illing *et al.* 2013 Sørensen Høifødt, Sexton, and Olstad 2004). Similarly Pearson and Lucas (2011b) suggested that challenging clinical cases, immediacy in clinical encounters and seeing patients’ problems in the context of their life provided real learning opportunities in a primary care teaching Practice. In addition, opportunities to participate in clinical work, was reported to be a key element of a positive training environment in hospital, motivating students to participate further in clinical activities (Boor *et al.* 2008). Similarly, Hoellein *et al.* (2007) showed that the level of student participation in ward rounds was a mark of quality teaching. Nevertheless Sørensen Høifødt, Sexton, and Olstad (2004) illustrated that although practical experience was essential for learning to occur, tasks needed to be tailored to the skills of doctors. They suggested that learning occurred in situations that were challenging but not too demanding to overwhelm learners.

2. Inclusive nature of clinical teams

Inclusion of junior doctors in medical teams was shown to encourage participation and to enhance learning by promoting professional thinking and coaching of clinical skills (Lempp, Cochrane, and Rees 2005; Sheehan, Wilkinson, and Billett 2005). It was also suggested to support the development of professional identity in both junior doctors and medical students (Weaver *et al.* 2011; Sheehan, Wilkinson, and Billett 2005).

3. Choice, independence and control over work

Having choice and independence in the workplace and control over work were found to be positively associated with a deep approach to learning leading to understanding, rather than learning by memorization, amongst hospital doctors

(Entwistle and Tait 1990; Delva *et al.* 2002; Delva *et al.* 2004; Kirby and Knapper *et al.* 2003; Kirby and Delva *et al.* 2003;). Similarly, opportunities to work independently were markers for good quality of General Practice placements by medical students (Van der zwet *et al.* 2010). On the contrary, lack of control over decision making was reported to be associated with psychological distress (Lavoie-Tremblay *et al.* 2008).

4. Supervision and feedback

The level of supervision of training doctors in clinical settings was recognised to be important in a number of studies. Approachability, availability, and the communication skills of ‘experts’ in the workplace were reported to impact on learning opportunities in both hospital and primary care settings (Lack and Cartmill 2005; Smith and Wiener-Ogilvie 2009; Van der zwet *et al.* 2010). Direct supervision enabled trainees to gain skills more rapidly (Kilminster *et al.* 2007). Observation of clinical procedures, guidance and feedback on performance were characteristics of good supervision (Ross *et al.* 2011). Direct, constructive feedback on trainees’ work or clinical errors assisted learning from mistakes (Lempp, Cochrane, and Rees 2005; Busari & Koot 2007; Kroll *et al.* 2008). Both feedback and supervision of training doctors were reported to be affected by service demands (Jelinek, Weiland, and Mackinlay 2010). In addition support for doctors in training was reported to be mediated by the working cultures of hospital departments (Ross *et al.* 2011; Farnan *et al.* 2009).

5. Organisational trust:

Likewise, trusting workplaces where errors can be discussed and constructive feedback given were suggested to maximise learning of training doctors in hospitals (Firth-Cozens 2004; Kroll *et al.* 2008).

6. Characteristics of the trainer/ supervisor

The characteristics of the supervisor were reported to be important to the facilitation of learning. Knowledge, teaching and feedback skills, approachability and enthusiasm were all reported by GP trainees to be important characteristics of a supervisors (Wall and Mcaleer 2000; Boendermaker *et al.* 2000; Silverstone *et al.* 2001; Smith 2004; Smith and Wiener-Ogilvie 2009). Conversely, ineffective supervisors' behaviour included rigidity, low empathy, arrogance, dogmatism and insensitivity (Cottrell *et al.* 2002; Alsultan 2011).

7. Workplace dynamic and relationship with supervisors:

Positive dynamic and relationships in the workplace were reported to be conducive to learning by GP trainees (Smith and Wiener-Ogilvie 2009). In particular the nature of the relationship between supervisors and trainees were reported to be determinant for learning. For example Fernald (2001) showed that a good, trusting relationships with supervisors helped students in General Practice to learn. Cornford and Carrington (2006) reported that good relationships with supervisors encouraged trainees to ask for advice while poor relationships inhibited enquiry. The level of supervision in a hospital setting was also reported to depend on the nature of the relationship between trainee and trainer (Kilminster and Jolly 2000; Cottrell *et al.* 2002).

8. Formal teaching:

Sørensen Høifødt, Sexton, and Olstad (2004) in a study of hospital psychiatry departments illustrated that the availability of formal teaching was predictive of learning benefits reported by junior doctors. They suggested that formal teaching time serves as an arena for reflection on clinical experience thereby supporting learning. In addition, protected and adequate time for formal learning, were

reported to be important for learning in General Practice (Smith 2004; Malrooney 2005; Smith & Wiener-Ogilvie 2009; Pearson and Lucas 2011a).

9. Opportunities for reflection:

It has also been suggested that opportunities for reflection promote learning from complex or new clinical experiences of doctors in training. Factors that were suggested as promoting reflection include time for reflection, interaction with others, effective guidance and supervision, as well as personal factors such as maturity (Slotnick 1996; Hunter *et al.* 2008). Reflection on clinical work and encounters with patients and colleagues were also shown to facilitate the development of professional identity (Weaver *et al.* 2011).

10. Workload:

A number of studies illustrated that heavy workload had a negative impact on learning. Delva *et al.* (2004) illustrated that heavy workload for doctors training in hospitals, was significantly associated with 'surface-disorganised' approaches for learning (i.e. feeling overwhelmed by work and lack of understanding of why tasks are performed). Similarly Stok-Koch, Bolhuis, and Koopmans (2007) reported that physician trainees commonly cited heavy workload as impeding learning. Nevertheless Celebi *et al.* (2012) did not find significant association between workload and reported supervised activities of medical students on medical wards.

Workplace environment and learning in General Practice:

A number of studies attempted to measure training doctors' satisfaction with their training environment (Klessig *et al.* 2000; Roff, McAleer, and Skinner 2005; Roth *et al.* 2006; Vieira 2008; Bloomfield and Subramaniam 2008; Boor *et al.* 2011). These studies used questionnaires, to try and quantify level of satisfaction of learners with their training environment. Questions were often pre-selected and agreed by a group

of educators with limited input from trainees. Malrooney (2005) developed an inventory to measure trainee satisfaction with General Practice-based attachments. Questions were asked about work at the Practice, the GP trainer, teaching and learning, and interaction with other health professionals. She concluded that a Practice-based environment was largely satisfactory for trainees in Ireland. Other more qualitative studies identified supervision and feedback as markers of quality in General Practice clerkships (Silverstone *et al.* 2001; Van der Zwet *et al.* 2010). However, assessing satisfaction gives little information as to how learning in training Practices actually occurs, and as to the characteristics of training Practices that promote learning.

Smith (2004) conducted in-depth interviews with 11 trainees in the South-East of Scotland in order to identify aspects of the learning climate that they perceived to be important. He identified that the balance between socio-emotional support for them as learners and their need for stimulation and challenge was particularly important. The personality of the trainer and the physical environment of the Practice were less important. In a later study, Smith and Wiener-Ogilvie (2009) conducted focus groups with GP trainees who described the learning climate of their training Practices under the following headings: the Practice (relationships, flexibility in adapting to their needs, ethos and physical facilities), the GP trainer (skills, knowledge, feedback and personal attributes), learning (perspectives, identification of learning needs and level of autonomy) and stress (workload, supervision and support, and clinical uncertainty). Although the focus groups covered a wide range of issues, it was difficult to examine in depth questions such as which experiences resulted in particular perceptions and which aspects of the training in particular affected opportunities to learn.

In another UK study, Cornford and Carrington (2006) investigated the problems encountered by GP trainees in their training Practices and how trainers and Practices supported them. The study focused on the transition period as trainees moved from hospital to General Practice. It suggested that the difficulty of defining shared goals between learner and Practice was the main reason for the problems trainees

encountered. Differences in Practice characteristics and learner identities accounted for variable learning experiences. The study highlighted the need for a positive relationship between trainee and trainer but did not investigate directly how learning occurred. It focused on the experience of GP trainees early on in their General Practice attachment and did not examine their perceptions at the end of their training.

Pearson and Lucas (2011a; 2011b), using a single descriptive case study of a training General Practice in England, indicated that learning occurred through engagement and opportunity. Engagement in learning was developed through acknowledgment of and respect for learners, clinical experience relevant to their learning needs and emotional responses to encounters with patients and tutors. Learning opportunities arose from authentic clinical encounters with patients within their social context and through learning from peers. The study did not focus on GP trainees but included all learners—medical and nursing students, foundation doctors and GP trainees. It highlighted the importance of making the learning experience and patient contact relevant to the needs of each group. Although the study identified important facilitators for learning in a training General Practice, it was a single case study. It did not examine negative cases, such as the impact of limited opportunities to engage or of fraught relationships between learner and supervisor.

Finally, Van der Zwet *et al.* (2011), having studied the learning experiences of medical students in General Practices in Holland, suggested that students needed ‘developmental space’ to develop their professional identity. They argued that central to General Practice clerkships were ‘holding independent consultations’, ‘talking about consultations’ and ‘observing GPs’. Contextual factors such as room availability, time for supervision, relationships with supervisors and team members all impacted on these activities. As the study concentrated on the experience of medical students, it emphasised the development of professional identity at an early stage in a doctor’s career.

2.4 Conclusions derived from the literature review on workplace learning.

The review has considered theoretical perspectives and models used to explore learning in the workplace. These perspectives suggest that the environment has a role in mediating both behavioural and cognitive processes for learning. The role of the environment in facilitating learning is particularly emphasised by social theories. In addition, published research suggests that the characteristics of the workplace environment can impact on opportunities to learn. In medicine, a number of characteristics of the training environment, particularly in hospital settings, were illustrated to impact on learning. These include opportunities to participate in clinical work, the inclusive nature of clinical teams, exercise of choice, independence and control over work, supervision and feedback, organisational trust, characteristic of supervisors, workplace dynamics and relationship with supervisor, availability of formal teaching, opportunities for reflection and workload.

There is a limited number of well-designed studies on learning during General Practice placements. The studies identified highlight that clinical encounters with patients are fundamental to the learning experience and suggest that contextual factors such as engagements and relationship with others in the Practice, formal supervision and teaching may impact on learning which is primarily derived from contact with patients.

It is not, however, clear how these findings relate to the experience of GP trainees whose learning goals may be distinct from those of medical students. Few studies focus specifically on the experience of GP trainees in the final stage of their training. There is a need further to explore how workplace dynamics, levels of supervision and workload affect learning opportunities in General Practice. Finally, it is unclear how the particular characteristics of a training Practice impact on a trainee's perception of being prepared. Although a number of studies identified issues that can affect learning, it is not clear how these issues impact on preparedness. The concept of preparedness and the literature related to it are discussed next.

2.5 Medical professionalism and the development of professional knowledge and identity

This section explores medical professionalism and the social and political influences particularly in the U.K. which have shaped it. Part of being prepared constitutes the development of professional attitudes, values and behaviours. The literature on preparedness does not on the face of it deal with the wider issues related to professional preparedness such as development, judgement, expert knowledge and identity, all of which are considered in this section by way of introduction to a review of literature on preparedness (section 2.6).

Medical professionalism

The nature of professionalism has been widely discussed in sociological and educational literature and is understood differently by authors. Johnson (1972) described professionalism as an ideology which enables professions to gain status and privileges. Eraut (1994) pointed out that occupations claiming to be professional have relied on a variety of modes of training, namely, internship, vocational training, examination by a qualified assessor, study at college or university, and practical competence as evidenced by log book or portfolio. Starr (1982) and Hilton and Southgate (2007) added that professions enjoy a degree of self-regulation, with an orientation towards moral and ethical standards of behaviour or service rather than towards profit. The autonomy to exercise judgement or discretion in a situation of uncertainty was highlighted as another unique characteristic of the professions (Coles 2002).

Cruess and Cruess (2008) suggest that there are two dominant approaches to the understanding of medical professionalism, namely, the sociological and the bioethical. The sociological approach rests on the relationship (social contract) between medicine and society. Society grants doctors autonomy, monopoly and self-regulation on the understanding that they have a collective responsibility to

demonstrate moral and professional integrity. As such, Cruess and Cruess argue, professionalism is a dynamic entity which evolves in line with the changes in the relationship between medicine and society.

The bioethical approach, on the other hand, focuses on attributes and values personal to the doctor–patient relationship such as altruism, respect, empathy, honesty, integrity, ethical and moral standards, accountability, and commitment to life-long learning and to the duty of advocacy.

A number of large and influential medical associations have spent considerable resources in an attempt to define medical professionalism, for example, the Physician Charter in 2002 (ACP-ASIM, ABIM and EFIM 2002; ABIM, ACP-ASIM and EFIM 2002; Blank *et al.* 2003), the ‘Good Medical Practice’ (GMC 2006) and the Working Party of the Royal College of Physicians (2005). These emphasise both the sociological and bioethical perspectives, on which other academic discussions of medical professionalism also build (Downie 1990; Benatar 1997; Wynia 1999; Swick 2000; Sturdyk, Lynch and Leach. 2003; Van De Camp *et al.* 2004).

Social and political changes and their effect on doctors

Sox (2009) suggested that professionals could be described as the offspring of the medieval craft guilds. The public status of the medical profession in the UK began to improve from 1850 onwards as a result of advances in medical science and of the requirement for doctors to master complex scientific knowledge and research.

Political and social change over the last 30 years has challenged some of the fundamental elements of medical professionalism such as the exclusive access to complex knowledge, the commitment to altruism and integrity, and the privilege of autonomy and self-regulation (Buyx *et al.* 2008). Such changes occurred both in the USA and the UK.

In the USA the arrival of ‘managed care’, ‘corporate medicine’ and ‘commercialism’ during the 1980s and 1990s was suggested to undermine the

fundamental professional values of clinical autonomy and discretionary decision-making and to clash with the commitment of doctors to the needs of their patients ahead of any personal gain (Hafferty 2006). The introduction of Physicians Pay for Performance initiatives have been argued to further shift the focus of doctors' work away from individual patient's needs.

Similar changes have occurred in the UK. Of particular importance are the contractual changes, introduced by the UK Department of Health in 2003 to the GMS contract, which defines how income of General Practices is generated. The contract links income to performance, rewarding practices which deliver evidence-based care, thereby focusing their work on areas which generate pay. The introduction of the contract was seen by the government as a major driver in improving patient care and removed the responsibility from GPs to deliver services Out of hours (during the night or weekends). The changes in the contract were accompanied by a new governmental focus on preventative health (Department of Health 1999; Department of Health 2004b). Indeed correspondence in the British Medical Journal frequently reflects the feeling that the target driven work, imposed by the GMS contract, interferes with patient-centred care (Heath *et al.* 2009 Spence 2013; Manners 2013). Consequently, it has been suggested that Pay for Performance initiatives encourage clinicians to neglect those aspects of good practice that are not measured or remunerated, thereby creating a public perception that doctors serve the interests of health management organisations rather than those of patients (Hendrickson 2008).

The creation of the National Institute for Clinical Excellence (NICE) is also seen as a challenge to autonomy and commitment to individual patients. NICE makes recommendations on the use of clinical treatments and medicines on the basis of cost-effectiveness rather than efficacy alone. Some argue that these changes have constituted the industrialisation of primary care services with an increase emphasis on the control of access of patients to services and the use of evidence based medicine to reduce variation in care offered to patients rather than to improve the quality of care offered (Llief 2008). Campbell and Chin (2009) are of the view that

the overall result is a narrowing of the professional identity of doctors to that of competent technicians as the relationship-centred approach which previously dominated primary care has been devalued.

The traditional notion that specialised expertise entitled the profession alone to determine the real needs of the client (Eraut 1994) has also come under threat. The general availability of scientific information over the internet and via the media, as well as advances in science, has raised public expectations as regards both access to and outcomes of medical care (Working Party RCGP 2005). Furthermore, events that undermined public trust in medicine also affected the life and work of doctors. High-profile cases, such as the mismanagement of children in need of cardiac surgery (Bristol Royal Infirmary in 2001), and Harold Shipman in 2000, a General Practitioner serial killer (Dame Janet Smith 2004), highlighted poor practice and failures in professional self-regulation, thus laying the foundation for a convincing political argument for stronger regulation of medicine as a profession. These events gave rise to a growing literature on professionalism in the UK, emphasising three pillars of professionalism and its relation to the revalidation process: expert knowledge and skills, ethics and service to patients (Irvine 2001). As a result, the GMC reviewed revalidation and licensing procedures and introduced mandatory revalidation for all doctors including GPs in 2012 (RCGP 2012; GMC 2012). Clinical governance frameworks to record, as well as agencies to audit and monitor, performance were developed within the NHS (for example, the Information Statistic Division in NHS Scotland and Quality Improvement Scotland).

Finally, the implementation of the European Working Time Directive (NHS Employers 2009) and the frequent moves by doctors between jobs during training following the implementation of MMC (2003) have led to the breakdown of traditional team structures in hospitals. These developments mirror changes in working patterns elsewhere in society. Sennett (1998), in his book 'The Corrosion of Character', describes how changing modern lifestyles, in particular the tendency for workers to change jobs frequently, has caused a loss of continuity and community. In this 'flexible capitalism', team-working structures emphasize mutual

responsiveness rather than personal validation. The lack of connectedness and of personal accountability, according to Sennett, leads to the ‘corrosion of character’ and to the loss of traditional professional values.

The effects of changes in the social and political climate are not unique to the medical profession. Many systems of professional self-regulation have experienced upheaval and undergone reform since the 1970s. Moran (2003) explains that governments have responded to changing social norms and institutional failings by extending the reach of their surveillance and of their control of the public sector. In a similar manner, Beck (2008) points to a series of government policies since 1979 which have rendered teachers to the control of regulatory agencies such as the Teaching Training Agency and Ofsted, bodies which have defined curriculum structures, introduced a culture of performance audit and a code of ethics, and regulated professional misconduct.

Professional judgement

The changes described above, particularly the introduction of the new GMS contract which was based on population-wide empirical data and related clinical guidelines, produced extensive debate about their impact on the role of GPs and on their ability to apply professional judgement. Gillies (2005), in a paper to the RCGP, argued that the GMS contract favoured evidence over the perceptive abilities of doctors which are the essence of the profession. GPs have to apply “perceptual capacity” or “situation appreciation” when dealing with patients. The ability of a doctor to read a situation correctly and to apply his or her experience or judgement is a form of “virtue ethics”. Virtue ethics are born of experience, referred to by Gillies as “practice of perception” and by Greenhalgh (2002) as “intuition”. Gillies derives the notion of judgement from Aristotle concept of “phronesis” (practical wisdom, the ability to decide correctly what to do in practical situations). Gillies takes the view that judgement, applied to complex problems and conflicting interests, requires a high level of reflection produced by experience and maturity which it takes time to develop.

Similarly, Hilton and Southgate (2007) describe the development of professional judgement as a process of moving from 'naïvete' to 'phronesis'. Professionalism needs time and develops in accordance with the individual's ability to reflect on her or his own actions and behaviour. Hilton and Southgate outline different stages in a doctor's professional development. They described medical students as having identity-role confusion and seeking approval and clarity over roles and duties. At this stage, Hilton and Southgate considered students to have 'pre-reflective thinking'. They suggested that senior medical students or junior doctors develop genuine interest in the welfare of others and employ quasi reflective thinking as they use personal beliefs to choose the evidence to support preconceived beliefs. Doctors in specialty training were deemed to be developing 'phronesis' as they engage in a higher level of reflective judgement through interaction with patients while mature professionals are those for whom moral and reflective judgement is maximal.

Professional judgement can also be defined in terms of Schon's (1983) 'reflective practice' as technical knowledge alone is not sufficient for dealing with complex problems (Hilton and Southgate 2007). Such reflective judgement develops in stages as adults deal with uncertainty (King and Kitchener 1994). Another theory linking the development of professional judgement to reflection is 'mindfulness' described by Epstein (1999). A mindful practitioner is one who combines technical with tacit knowledge, personal values, self-observation and curiosity. Reflection and self-assessment are at the core of mindfulness.

The development of expert knowledge

Ericsson, Prietula, and Cokely (2007), drawing on studies of musical performance, physical activities and chess, suggested that the development of expertise was dependent on the number of hours spent in what he called 'deliberate practice'. Immediate feedback, combined with opportunities to correct performance, improved skills. Similarly, Bereiter and Scardamalia (1993) argued that the development of expertise was a deliberate choice, requiring learners to work at the upper limit of their abilities.

Dreyfus and Dreyfus (1986) developed a well-known model for the acquisition in stages of knowledge and skills by adults, initially based on the training of pilots. Batalden *et al.* (2002) describe how this model could be applied to the development in five stages of knowledge and skills in medicine: (1) novice stage, when the student learns to take a medical history, (2) advance beginner stage, when the student discerns the common in different situations, (3) competent stage, when the doctor learns to plan an approach to each patient situation while still being supervised, (4) proficient stage, when the specialist physician develops routines and manages distracting stimuli, (5) expert stage, when the physician recognises patterns of discrete clues by applying what can be referred to as 'intuition'. Similarly, Benner's theory of expert intuition also draws on the work of Dreyfus and Dreyfus (Benner and Tanner 1987). The model emphasises the importance for the development of intuition of knowing the patient and of being emotionally involved (Gobet and Chassy 2008; Cash 1995).

The development of expertise through experience is also described in literature on decision-making processes of doctors (Schmidt and Rikers 2007; Lonka 2009), with a number of authors providing cognitive models. Schmidt and Rikers (2007) suggested that the application by experienced clinicians of pre-encapsulated concepts speeds up decision-making. Similarly, Case, Harrison, and Roskell (2000), in a qualitative study investigating the differences in clinical reasoning between novices and experts, suggested that experts used superior cognitive strategies as their knowledge base was better organised.

Social-cultural perspectives have also been canvassed (Lonka 2009; Billett 1996). Billett (1996) claimed that expertise developed through immersion in a particular social situation over time, promoting not only knowledge but also the ability to engage in the discourse, norms and practices of that community. Expertise depends on access to social practice. Sfard (1998) and Lonka (2009) added the opinion that cognitive and social processes are interlinked, with participation in cultural practices and shared activities structuring and shaping cognitive processes.

The development of professional identity

Burford (2012) suggested that the process of becoming a doctor is not just a matter of gaining medical knowledge and skill but also of developing a professional identity, a view shared by Rees Monrouxe (2010).

The professional socialization documented in the classic 'Boys in White' (Becker 1961) and 'Student Physician' (Merton and Research 1957) dealt almost exclusively with single white middle-upper class males. Nevertheless, Beagan (2001) in a more recent study of medical students in Canada, reports that little has changed. Socialisation involves a sense of 'entitlement' (to touch patients and to probe emotional states), changes in language and communication (reducing the patient to body parts and disease), learning about hierarchy within medicine and relationships with patients (power sharing or emotional distance) and the sacrifice of self-identity (either by segregation of their other identity or by letting go of it). In addition, Weaver *et al.* (2011) suggested that interaction with patients during hospital placements and being treated as future medical professionals by other doctors and lecturers contributed to the development of professional identity

Both social identity and self-categorisation theories bring their perspectives to the development of professional identity. The former suggests that people have multiple social identities depending on the group with which they interact, the latter that people shift from identifying themselves as individuals to seeing themselves as members of a group with a shared identity (Weaver *et al.* 2011).

Monrouxe (2010) suggested that the construction of professional identity of doctors involves both psychological processes internal to the individual and social process through language and artefacts. Identity is constructed and co-constructed through talk as individuals tell the stories of their everyday experiences. Relationships with colleagues and seniors are therefore paramount to the development of identification.

2.6 Conclusions derived from the literature on medical professionalism

In summary, this review suggests that the definition of medical professionalism is evolving and shaped by ongoing and dynamic social and political changes. It is therefore likely that doctors will be required to adapt their professional approach accordingly and that this process is likely to extend beyond the training period.

The conceptual models on the development of professional judgement proposed by Gillies (2005), Greenhalgh (2002) and Hilton and Southgate (2007) suggest that judgement is developed over time and derived from doctors' own experience, alluding to an internal process which extends beyond the official training period.

While the Benner and the Dreyfus and Dreyfus expert knowledge models are particularly applicable to the period of medical training, they too emphasise the cognitive aspect. Social-cultural perspectives suggest that expertise is developed through immersion in social situations. Such perspectives are also used to explain the development of expert knowledge and professional identity.

2.7. Preparedness

In the past decade, the medical education literature on preparedness has been growing. In the UK, this rising interest has coincided with a growing emphasis on patient safety and the consequent desire to ensure that doctors are performing well.

This section reviews the literature on preparedness and presents research findings in relation to preparedness of medical students, junior doctors, more senior doctors and GP trainees. In addition, it examines various definitions of preparedness as well as alternative concepts such as 'transition' and 'trustworthiness'.

Studies examining preparedness of medical students and junior doctors

A number of studies have examined the preparedness (defined in a number of ways) of medical students and junior doctors. Godefrooij *et al.* (2010), in focus groups with medical students in the Netherlands, examined their perceptions of themselves as

being prepared for junior doctor roles. The students felt well prepared for clinical practice and did not feel daunted by the gap between preclinical and clinical training. Similarly, a number of surveys examined whether junior doctors considered that their medical schools prepared them well for their job (Goldacre *et al.* 2003; Goldacre, Taylor, and Lambert 2010; Ochsmann *et al.* 2011). The Goldacre, Taylor, and Lambert (2010) survey showed that 50.3% of 2002 medical graduates and 58.8% of 2005 medical graduates agreed that their medical school prepared them well, although with some variations between schools.

Cave *et al.* (2009), in a survey of the factors associated with the self-perceived levels of preparedness of all newly qualified doctors in the U.K. in 2005, found that both personal traits and environmental factors determined those levels. Individuals who scored highly on conscientiousness and extroversion felt relatively better prepared than those with high neuroticism ratings. However, multiple regression analysis of the data identified environmental factors (relevance of undergraduate training to future work and ease of getting help while working as a junior doctor) as the largest contributors to feeling prepared. Only 15% of doctors in this study felt poorly prepared by their medical school.

Other studies examined self assessment of competencies. Barsona *et al.* (2011), who examined in a survey study such self-assessment regarding the skills, knowledge, attitudes and behaviour of medical students in Portuguese-speaking countries, found lower levels of competence reported in relation to knowledge and clinical skills than in relation to attitudes and behaviour. Other studies have defined preparedness as reported self-confidence or belief in the ability to carry out procedural tasks, communicate, make clinical assessments and judgments, and deal with certain clinical situations (Ochsmann *et al.* 2011; Goldacre *et al.* 2003; Billings, Curtis, and Engelberg 2009; Goldacre, Taylor, and Lambert 2010; Kelly, Noonan, and Monagle 2011; Gibbins, McCoubrie, and Forbes 2011).

Ochsmann *et al.* (2011) for example, in a German survey of junior doctors, found that a sense of being poorly prepared was associated with self-reported deficiencies

in skills such as ECG interpretation, therapy planning and dealing with emergency cases. In the UK, the GMC commissioned a multi-methods longitudinal study of students' preparedness for foundation programme (Illing *et al.* 2008, Illing *et al.* 2013). The study found that, although foundation doctors felt prepared for basic clinical tasks, including history taking, and were confident with their communication skills, they felt underprepared in prescribing and less prepared to deal with acutely ill patients, workload management and being 'on call'. The study concluded that preparedness could be improved by providing more experience in clinical practice as part of undergraduate training, an approach supported by other findings. Specifically Billings, Curtis, and Engelberg (2009) and Kelly, Noonan, and Monagle (2011) report that the more experienced junior doctors were in performing a task, the more confident they felt about it.

The opinions of others have also been used to measure preparedness. Matheson and Matheson (2009) surveyed the extent to which first-year doctors in the UK were deemed by specialist registrars or consultants to be prepared for work, based on the competencies outlined in '*Tomorrow Doctors*'. The indications were that graduates were best prepared for working in teams, for communicating with relatives and colleagues, for taking histories and clinical examinations but least prepared in diagnosis and decision-making, in clinical practical skills and in complex communication skills.

Studies examining preparedness of senior doctors in hospitals

A number of studies examined preparedness of more senior doctors by measuring self reported confidence or perceived preparedness in relation to certain skills or roles. Hayes *et al.* (2007), in a survey of interns in Canada, reported that almost half of them felt unprepared to lead cardiac arrest teams. Studies of self-perceived preparedness of 'attending physicians' and 'consultants' show that early career physicians and consultants, while considering that their training prepares them for their clinical role in terms of medical knowledge and skills (Westerman *et al.* 2010; Brown *et al.* 2009; McKinstry *et al.* 2005), feel less prepared to deal with management issues and finance (Brown *et al.* 2009), managerial and leadership roles

(Westerman *et al.* 2010), negotiation, appraisal, business planning, medico-legal questions and managing private practice (McKinstry *et al.* 2005). Time spent in training was not related to such perceived levels of competence (McKinstry *et al.* 2005).

In summary, surveys of medical students and of junior and senior doctors have focused primarily on hospital-based work in examining preparedness in one of the following ways:

- Self-perception of being generally prepared.
- Self-assessment of competence in relation to skills, knowledge, attitudes and behaviour.
- The feeling of preparedness for or ‘confidence’ in carrying out procedures, communication-related tasks, assessments or particular roles.
- The views of others.

Research suggests that junior doctors are under-prepared for some tasks and skills. Greater experience during undergraduate training in tasks and clinical skills relevant to future roles was suggested to enhance preparedness. Senior doctors were reported to feel prepared for their clinical roles but less so for managerial and leadership tasks.

Studies examining preparedness of GP trainees.

A number of studies on preparedness of GP trainees to their future role examined the benefit of having an extended General Practice placement in comparison to a standard placement. The majority of these studies examined the benefits of an extended General Practice placement prior to the introduction of the new General Practice training curriculum and of the extension of the placement component from 12 to 18 months.

In Scotland, McKinstry, Dodd, and Baldwin (2001), looking into the question of confidence in fulfilling the role of a single-handed GP, compared the self-

assessments of 39 trainees in standard 12-month placements with those of 35 in extended 18-month placements. Trainees in extended placements were significantly more confident (90% versus 53%). In addition, trainees in extended placements felt that they addressed their educational needs more successfully than those in standard placements. The knowledge deficits most commonly reported by trainees in standard placements related to dermatology, paediatrics, ophthalmology, management skills and chronic disease management. The most commonly reported benefits of extended placements were the opportunities to work in an additional Practice, to consolidate experience and gain confidence, to be in an examination-free environment, and to undertake audit or research. Similarly, Field, Mathers and Lane (2002), in a small qualitative study designed to evaluate the experience of trainees in Trent, found that working in two different Practices increased trainees' confidence.

McKinstry *et al.* (2001, 2004) also asked GP trainers whether their trainees were ready for independent practice as single-handed GPs. Ten percent in the 2001 study and nearly half in the 2004 felt that their trainees were not ready after a 12-month placement and would benefit from additional experience.

Sibbett *et al.* (2003), in a focus group study of trainees in Ireland, evaluated the perceived benefit of 18-month General Practice placements. They compared the experience of six trainees in extended placements with that of seven in standard 12-month placements. Trainees in extended placements felt that the longer period allowed further focus on patient care and promoted self-directed learning. They were more confident in their clinical judgement (for example, in emergency psychiatric admissions, grey areas such as knowing when to admit and when not) and in dealing with assertive patients. Extended placements also promoted team work. The experience of working in two General Practice settings was enriching and supported the evaluation of various approaches to clinical issues. However, trainees in the extended placements still felt unprepared for Practice management and 'self care'. Trainees in 12-month placements, on the other hand, felt that their clinical judgement was not sufficiently developed and were concerned that they needed support in making decisions.

A number of studies have pointed out that because the 12-month placement as the final year of vocational training was burdened with examinations and assessments, it did not allow trainees to develop the skills required for independent practice or to address their individual training needs (Bowler 2005; McKinstry 2001; Sibbett *et al.* 2003; Elwyn 1998). Furthermore, it was suggested that trainees preferred some of the General Practice training component to be carried out before they embarked on their hospital posts (Little 1994). It is worthy of note that these studies were carried out prior to the extension of placements from 12 to 18 months.

O'Shea (2009), having reviewed the literature on traditional training programmes in General Practice including earlier studies by Ashworth *et al.* (1997), Baron *et al.* (1998), Harrison and Van Zwanenberg (1998), identified a general concern about poor preparation for independent practice, particularly in relation to Practice management and organisation, legal issues and finance.

A more recent RCGP report presenting the educational case for the extension of General Practice training (Gerada, Riley and Simon 2012) suggested that trainees themselves recognise the need for longer training. The authors cited findings from a survey presented at the 2011 annual RCGP conference to the effect that 41% of trainees believed that their three-year GP training period, which included 18 months of placements, did not prepare them adequately for a career in General Practice. In addition, the report claimed that *'Weaknesses in current UK GP training have been identified in a number of specific clinical areas such as care for children, care for those with mental health problems, care for those with dementia and care for people living in residential care homes.'* (p20). Similarly, Lawrence (2012), in a survey of GP trainees and early career GPs, reported that 44% of the former and 50% of the latter indicated that they would have elected to do a four-year programme had it been available instead of the standard three years. Survey respondents felt that extended training would strengthen clinical skills, enable in-depth understanding of General Practice and provide opportunities to develop specialist interests. However, because response rates for both surveys (Gerada, Riley and Simon 2012; Lawrence 2012) are not available, it is difficult to judge the general applicability of their findings.

On the other hand, a recent evaluation by Warwick medical school of the RCGP training curriculum (Bedward *et al.* 2011), using a qualitative approach of focus groups and interviews with 50 GP trainees from five UK Deaneries, suggested that trainees in their third and final year of training felt generally confident to embark on a career in General Practice, albeit recognising the need for continued learning throughout their careers. The study identified perceived gaps in knowledge and experience in the business side of General Practice, clinical governance, research, continuous care, dealing with uncertainty and some key specialities. This study was carried out following the extension of placements to 18 months.

In summary, research into the preparedness of GP trainees, having examined self-perceptions, has identified a lack of confidence or experience in areas such as audit and research (McKinstry, Dodd, and Baldwin 2001; Bedward *et al.* 2011) and Practice business/management (Bedward *et al.* 2011; Sibbett 2003; O'Shea 2009). Knowledge deficits in some clinical areas are also reported (Bedward *et al.* 2011; McKinstry, Dodd, and Baldwin 2001; Sibbett 2003). The studies by McKinstry *et al.* (2001, 2004) examined preparedness by seeking the opinions of others. However, they defined preparedness as the ability to work as a 'single-handed' GP, a definition which is less applicable to the reality of General Practice nowadays. Only the studies by Bedward *et al.* (2011), Gerada, Riley and Simon (2012) and Lawrence (2012) were conducted following the extension of the placement period. Despite identifying a perceived lack of knowledge in certain areas, Bedward *et al.* (2011) found that trainees felt confident about embarking on their careers. This was in contrast to survey findings by Gerada, Riley and Simon (2012) and Lawrence (2012). Nevertheless, the findings by Gerada, Riley, Simon and Lawrence are less reliable and their neutrality is questionable, as these surveys were used to peruse a political argument.

Preparedness or transition?

More recently, the very concept of preparedness has been challenged in medical education literature. Kilminster *et al.* (2011) argue that the emphasis of government

and universities on the need to improve the individual doctor's preparedness for practice is flawed because their approach assumes that learning is transferable from medical school to clinical practice setting. They suggested that, on the contrary, attention should be paid to the challenges associated with the transitional stages of a doctor's career. These stages are inherently stressful due to difficulties in understanding expectations and new roles and should, therefore, be viewed as critical periods of intensive learning.

Teunissen and Westerman (2011) have reviewed literature on the transitions experienced by medical students and doctors. They conclude that transition is not a moment but rather a dynamic process in which the individual moves from one set of circumstances to another, with transition periods being associated with major changes in tasks, responsibilities and expectations. They identified three key transition periods within medical education: the first when the non-clinical student starts clinical training, the second when the graduate starts work as a junior doctor, and the third when the specialist trainee finishes postgraduate training and takes up a specialist post. There may be other transitions, for example in the UK, the moves from pre- to post-registration after the first year of the foundation programme and from the foundation into the specialty programme also constitute transition periods.

A number of studies examined difficulties associated with transition periods:

Transition of medical students to the start of clinical work

Reviewing published research, Teunissen and Westerman (2011) suggested that at the start of their clinical work, medical students perceive difficulties in interaction with patients and medical staff. During this period they learn to take responsibility in directing their own learning.

Transition from undergraduate to junior doctor role

In a qualitative study using interviews and audio diaries of 31 foundation doctors in the UK, Brennan *et al.* (2010) reported a number of challenges associated with the transition from undergraduate to junior doctor role. Taking responsibility,

particularly for prescribing, dealing with uncertainty, working in multidisciplinary teams and experience of sudden death were all reported as challenges during such transition periods. Similarly, Teunissen and Westerman's review (2011) identified that new doctors suffered from burnout due to the undertaking of the multiple responsibilities associated with patient care and the need to undertake tasks independently.

Transition from hospital work to primary care/ General Practice work

Martin (2009), using a case study approach, examined the transition of students into Postgraduate training in a Canadian Family Practice. Although at the beginning of their attachment, former students were uncertain about their medical expertise and skills, continuity of patient care, in particular, was influential in assisting them to gain confidence and to learn the role of Family Physician.

In a qualitative study of interviews and focus groups with 32 trainees transferred from hospital to General Practice, Cornford and Carrington (2006) identified the main areas of difficulties during such transitions as being social isolation, managing knowledge gaps and carrying out home visits.

Transition into specialist/ senior doctor posts

Westerman *et al.* (2010) interviewing 14 newly appointed physicians in the Netherlands, identified that the main differences between residency training and working as an attending physicians, equivalent of UK consultants, related to non clinical work such as finance matters and writing business plans, leadership and supervision responsibilities, carrying ultimate medical responsibility and familiarity with local structures, culture, policies and patient population. Consequently, Teunissen and Westerman (2011) concluded that, doctors taking up specialist posts feel challenged by the additional financial responsibilities of patient care and by the demands of supervising others.

These findings are similar to those made by Brown *et al.* (2009) in their investigation of transition from the end of specialist training to the beginning of practice as a consultant in the UK. In a mixed methods study of interviews and questionnaires

with 45 newly appointed consultants, they noted that transition was initially associated with uncertainty and the difficulty of coming to terms with the leadership role expected by their teams. Stress eased over time, particularly when working in supportive environments.

Commenting on Westerman *et al.* study and drawing on literature from transition psychology, Kumagai (2010) considered that the inevitably disruptive changes associated with transition and the critical reflections resulting from them should be welcomed for developing a thoughtful approach to patient care in new physicians. Although encountering unfamiliar tasks and roles in new contexts initially produces feelings of incompetence and failure, it also stimulates self-inquiry and assessment leading eventually to a sense of mastery and personal growth.

Transition period and performance of doctors:

Kilminster *et al.* (2010 and 2011), in a case study of a care of the elderly department in the UK, examined performance during the key transitions of (1) students moving into the foundation year (first year of medical practice) and (2) doctors moving from generalist to specialist clinical practice (foundation year two into specialty training). Their findings suggested that actual learning and performance during transition were not determined by regulatory frameworks, such as training standards, but rather by situation and context. Actual practice depended on local setting, make-up of the team, time of day and the way the team viewed the doctor's performance. Thus, for example, the level of responsibility assigned to the doctor depended on the team's available skills at that particular time, induction was often missed if a new doctor started on night shift, and supervision relied on the consultant's own engagement with their educational role. The way others in the team evaluated trainees' performance affected the availability of work and learning opportunities. A positive assessment meant more chances to practise different skills in a supportive environment.

Based on these findings, Kilminster *et al.* argued that doctors must never be assumed to be prepared in advance of transition because their performance did not depend solely on their individual attributes and prior knowledge but was fundamentally affected by organisational factors and local circumstances.

Teunissen and Westerman (2011), however, maintain that the ability to adjust to new environments, the level of motivation and the existence of active learning strategies also have roles in easing transition. Sheehan, Wilkinson, and Billett (2005) suggest that the environment and the individual both play a part in shaping transition. In a qualitative study of interviews and focus groups with interns in New Zealand, they identified as positive factors that encouraged participation and learning by junior doctors the nature of the team, the behaviour of supervisors and the personal attributes of the trainee. Drawing on their findings, they concluded that transition from medical school to junior hospital doctor, was a reciprocal process dependent both on the junior doctor's ability and on the support provided in the workplace. Similarly Deppoliti (2008), exploring the experience of early career nurses, suggested that the relationship with supervisors and colleagues was paramount for successful transition.

Finally, Burford (2012) takes the position that transitions (from foundation student, to specialty trainee, to consultant) involve changes in professional identity influenced by both personal and environmental factors such as knowledge, practical experience and feedback in the form of reinforcement from seniors. He suggested that problems in negotiating transitions may be related to failure to self-categorise as a doctor.

In summary, transition has been posited as an alternative to preparedness. A number of major transition periods and their attendant difficulties have been identified, the difficulties normally occurring due to changes in roles and responsibilities. It has been argued that such difficulties need to be viewed in the context of professional and identity development and not as an indication of a lack of preparedness. The literature suggests that the individual and the environment together shape learning opportunities and performance during transition periods.

Trustworthiness as an alternative concept to preparedness

A number of authors have suggested that preparedness can be measured by the trust others have in the doctor's ability. Indeed, as described in earlier sections, a number of studies sought the opinion of supervisors on how well trainees were prepared (McKinstry, Dodd, and Baldwin 2001; McKinstry B. *et al.* 2004; Matheson and Matheson 2009).

Kennedy *et al.* (2008), in a study using brief and in-depth interviews as well as observations of a large clinical teaching team in a Canadian emergency medicine unit, examined the grounds upon which supervisors assessed the readiness of trainees. They concluded that supervising physicians made assessments of competence or readiness for independent practice on the basis of 'trustworthiness'. They suggested that 'Trustworthiness' involved consideration of four elements: knowledge and skills, awareness of limitations (discernment of limitation), truthfulness and transparency between trainee and supervisor, and conscientiousness (thoroughness in data gathering and following up tasks). The study argued that achieving 'trustworthiness' is an essential step on a doctor's journey towards independent practice. From this it follows that being trusted by others can motivate trainees to work on their own.

2.8 Conclusions derived from the literature review on preparedness

Research studies have defined preparedness in a variety of ways. It has been described in terms of self-perception of preparedness or self-assessment of competence or confidence in carrying out particular skills and tasks. It has also been interpreted in the light of the trust others have in the doctor's abilities. Transition too has been suggested as an alternative concept to preparedness. No study, however, has examined what preparedness actually means to trainee doctors since it is generally deemed to be a pre-determined concept.

Studies have shown that the training environment has a role in shaping the self-perception of being prepared. Experience in relevant clinical skills during undergraduate training as well as support during junior training posts enhance that perception. Similarly, studies on transition suggest that the training environment can shape opportunities to learn and perform. Nevertheless, there is limited evidence as to the characteristics of the training environment for graduate doctors that are preparing. For example Kennedy *et al.* (2005) pointed out that evidence on the effectiveness of different levels of supervision was lacking and that excess supervision may impede the development of self-regulatory capacities essential for independent practice.

No study has directly investigated the impact of the postgraduate training environment of doctors on perceived preparedness. In particular, little is known about how the experiences of General Practice trainees in General Practices are linked to their perceptions of preparedness.

There is no large volume of high quality studies examining preparedness of GP trainees. Majority of the studies are small scale, Deanery based studies, often seeking the opinion of trainees in extended versus non-extended training schemes. The exceptions are the studies by McKinsty, Dodd and Baldwin (2001) and McKinsty (2001, 2004) which were larger studies of a higher quality. However these studies were conducted prior to the extension of General Practice placements and the introduction of the new RCGP curriculum and revised assessment procedures. Only 3 studies were conducted more recently reflecting current training arrangements. Two of these studies were of poor quality (Gerada, Riley and Simon 2012 and Larence 2012). The only recent high quality study is that of Bedward et al (2011) which provides more reliable evidence. Nevertheless although this study identified good confidence levels and some gaps in knowledge and experiences of GP trainees, it did not explain how the characteristics of the training environment relate to the perception of preparedness.

2.9 Summary

This Chapter outlined the approach taken for the literature review and its limitations. Learning theories relevant to workplace learning were described and research on workplace learning outlined with particular reference to findings from workplace learning of doctors. In addition, literature relating to the development of professionalism, professional judgement and knowledge was briefly discussed and the examination of the notion of preparedness by medical education literature was reviewed. The review identified limited studies of postgraduate trainees in General Practice. In addition, although a number of characteristics of the working and training environment have been identified as promoting learning, it is unclear how the particular characteristics of training General Practices impact on trainees' perceptions of being prepared.

Chapter 3: Methodology and Method

This Chapter outlines the rationale for and the purpose of the study. The considerations for the research approach and research method are explained. Ethical issues and the analytical approach are discussed as well as the actions taken to enhance the validity and reliability of the study.

3.1 Rationale for the study

This study is prompted by and builds on work I carried out in 2007. At that time, as part of my quality assurance work at the South East Deanery, a fellow investigator and I conducted seven focus groups made up of 67 GP trainees. The purpose of that pilot study, reported elsewhere (Smith and Wiener-Ogilvie 2009), was to describe the learning climate of training Practices from the perspective of learners. Trainees were asked to describe what in their opinion were the characteristics of a good training Practice, what constituted a good GP trainer, what made training within a Practice stressful and what motivated them to learn during the training year.

Five overlapping themes were identified: ‘the Practice’ (for example, feeling an integral part of the web of relationships and being comfortable approaching members of the Practice team, a positive dynamic within the Practice, attendance at Practice meetings, adaptability of the Practice in addressing trainees’ needs, and a positive ethos); ‘the GP trainer’ (knowledge, skills and attitude, in particular feedback skills, familiarity with the assessment process, honesty and enthusiasm); ‘the learning’ (access to different perspectives and balance between autonomy and control); ‘stress’ (level of supervision, appropriate balance between workload and time for learning, dealing with uncertainties and examination preparation); and ‘tutorials’ (good communication of judgments, needs-based planning and sufficient challenge). Because at that time the RCGP had introduced new membership examinations (as described in Chapter 2), some of the discussion in the focus groups centred around both the uncertainties created by the new model and the challenges it presented to trainers.

In discussing the attributes of a good training Practice, it became apparent that there were great variations in relation to the issues identified. Although the focus groups pinpointed a wide range of issues, it was difficult to examine these in more depth. Which specific experiences, for example, brought about the development of particular perceptions (such as feeling an integral part, having a positive ethos) and how did local circumstances determine or influence these perceptions? In addition, as the literature review in Chapter 2 has already highlighted, despite a wide range of theoretical perspectives on workplace learning and the characteristics of the workplace environment conducive to learning, there are limited published studies on learning specifically in a General Practice environment with existing studies focusing on more junior learners (medical students or GP trainees earlier on in their training). I therefore felt there was a need to examine these issues in more depth in a further study. In particular, I felt it was important to examine these issues once the new examination model was embedded in General Practice training.

Although trainees discussed aspects or attributes of training Practices that impacted on their learning experience while in training, it was not clear how these aspects were perceived to impact on preparedness for future work as qualified GPs. As the review of literature in Chapter 2 highlighted, little is known on the way the workplace training environment of doctors impacts on their perception of professional preparedness. In particular, little is known about the experiences of General Practice trainees and how they are linked to their own perceptions of preparedness. Moreover, no study has explored the perspective of early career GPs upon completion of their training. Such a perspective is important as it can illuminate the types of experiences which facilitate a smoother transition into independent practice and how the training environment in General Practice can shape such experiences. As the component of training in a General Practice setting has increased from 12 to 18 months since 2008, with plans to extend it further, there is a need to gain a greater understanding of the impact of the General Practice training environment on the perception of preparedness for practice. Finally, understanding what constitutes preparedness, particularly from trainees' and early career GPs' perspectives, will assist those

delivering training programmes and policy makers in designing training programmes which will prepare trainees far more effectively.

3.2 The aim of the present study and research questions

The overall aim of the study was to explore both the way in which GP trainees and early career General Practitioners describe their training environment in General Practice and the way they perceive that environment to impact on their preparedness on completion of training.

In particular, the study objectives were to answer the following research questions:

- How do GP trainees and early career GPs describe their training environment in General Practices?
- What meanings do GP trainees and early career GPs attach to preparedness for practice?
- In what way do GP trainees and early career GPs perceive their training environment to impact on their preparedness?

In the context of the research questions, preparedness for practice relates to the preparedness to practice as a GP.

3.3 Methodology and research approach: Interpretive approach

The research study described in this thesis is informed by the interpretive paradigm. The purpose of this section is to define and explain these approaches and their ontological and epistemological assumptions, as recommended by a number of writers in social science and education fields (Neuman 1997; Pring 2000; Creswell 2007).

Approaches to qualitative research can be classified in a variety of ways with several typologies being suggested in the literature (Creswell 2007). Such typologies are often referred to as paradigms. A paradigm is defined as '*a basic set of beliefs that guide actions*' (Guba 1990 p17)'. Each paradigm is defined by certain assumptions and underpinnings on the nature of reality (ontology), the perceived relationship with knowledge (epistemology) and how to go about conducting the research (methodology).

The constructivism paradigm is also known as the interpretive paradigm (Schwandt 1994). The interpretive paradigm combines two threads of thoughts which can be traced back to Greek and Roman philosophies: the first is Plato's idea that the experience of the senses (empiricism) is not always the best way of knowing something; the second is relativism, the idea that the reality we perceive is always conditioned by our experiences and culture. This paradigm sees humans as social animals who construct their own realities through social interaction (Willis 2007).

William Dilthey, a German historian and philosopher (1833-1911), elaborated on the notion of interpretivism. He distinguished between two types of knowledge, namely, understanding and explanation. Generalisation, he argued, was suitable for the natural sciences but not for the social sciences. When it came to social sciences, he rejected the objectivity of natural sciences which seeks explanation as the purpose of research. Since understanding only occurs in context, objectivity is irrelevant. His view was that the purpose of social science research was to 'understand' ('verstehen'). Although Dilthey's earlier works focused on psychological understanding, his later work looked at the construction of meaning as a cultural product (Delanty and Strydom 2003).

Schwandt (1994) contended that 'verstehen' is more than 'getting into the actor's head' but is rather about grasping meanings and symbolizing activities that constitute social life. He suggested that historically interpretivists have argued for the uniqueness of human inquiry. They claimed that the goal of social science is to

understand the meaning of social phenomena. Interpretivism assumes that *'human behaviour is purposive and that meanings are created, negotiated, sustained and modified within a specific context of human behaviour'* (Schwandt 1994 p 225).

Describing the interpretive approach, Pring (2000 p98) suggested that *'we each inhabit subjective worlds of meaning through which we interpret the social world. The social world is therefore nothing more than our own interpretation'*. That approach seeks to comprehend how people understand and interpret situations, the 'subjective meaning' (feelings, personal connotations or associations that accompany a statement, gesture or action) they attach to these, and their own thinking and intentions. The aim of the interpretivist researcher is, therefore, to reveal the interpretations of the situation by the social actors. Denzin (1994) argued that interpretation is an art which can be learnt only through practice. He suggests that *'interpretive research should emphasise socially constructed realities, local generalisation, interpretive resources, stocks of knowledge, intersubjectivity, practical reasoning and ordinary talk therefore providing multiple perspectives inherent in humans and detailed explanation of the context in which the research was constructed'* (Denzin 1994 p.502). Denzin, like Dilthey, rejects the emphasis on objectivity in research and argues that any interpretation of data by humans is inherently subjective.

In summary, the goal of interpretive research is to offer a perspective that helps to explain a particular phenomenon. Findings are specific to the phenomenon with its particular set of circumstances. This paradigm emphasises the need for multiple perspectives to correspond with a variety of views of the world. The researcher, by attempting to establish meanings, participates in their production (Schwandt 1994). Denzin (1971) suggested that researchers adopting this approach move between the realm of general social theory and the world of the people they inquire about. In addition, he posited that, in interpretive research, researcher and subject enter a double hermeneutic circle where both interpretations of the 'story' interact (Denzin 2002).

Since the objectives of the present study are to explore how GP trainees and newly qualified General Practitioners describe their training environment in General Practice, the meaning they attach to the concept of 'preparedness' and the way they perceive their training environment to impact on their preparedness, the research seeks to explore reflections of doctors upon situations they encounter and their interpretation of these situations. An interpretive approach therefore commends itself.

Consideration of alternative paradigms for the research

I have also considered the possibility of drawing on other research paradigms in conducting this study. One paradigm I considered was Critical Theory. This approach, which is rooted in Marxist concepts, critiques society systems of dominance and dependence. Nevertheless, critical theory assumes power relationships in social situations, for example between trainees and trainers, students and teacher. It was important to me not to assume in advance that such power relationships exist or dominate the nature of the training in interpreting the data. I therefore felt this paradigm was less useful in exploring my research questions.

I have also considered Action Research as a way for approaching the study. Action Research, which was first described by Kurt Lewin in the 1930s, has an interactive enquiry process at its centre, with the researcher working with community of participants to improve their actions or the environment in which they are working (Adelman 1993). The aim of Action Research is to bring about change in practice during the research process with the research concentrating on change and evaluation (Cooper and Endacott 2007). As this the present study was not designed to implement change in the environment of GP trainees, after consideration action research was deemed inappropriate for the purpose of my study.

Finally, I considered the use of Interpretive Phenomenology as described by Smith, Flowers and Larkin (2009). This particular approach builds on the work of Immanuel

Kant and Alfred Shütz, and focuses on subjectivity, consciousness and psychological understanding. Interpretive Phenomenology is useful in the exploration of a particular phenomenon for example the experience of an illness and its related psychological processes. As the intention of my research was not to explore psychological processes, after consideration I felt this approach was less useful for my study.

3.4 My own ontological position and how it may have shaped the study

Creswell (2007) has suggested that, by its very nature, qualitative research means that the researcher interprets what is seen, heard or understood. Background and prior understanding shape the researcher's reading of the data. It is, therefore, essential to remain aware and transparent about views and attitudes.

My own ontological stance, my philosophical assumption about the nature of reality and hence the assumption underlying this research, is that reality is subjective and may be viewed differently by different people. My research background started off with a positivist approach, emphasising objectivity, generalised causation and value-free inquiry (Paley and Lilford 2011) and I initially used purely quantitative methods. I have since moved in the direction of a mixed method approach, gradually shifting towards conducting research using purely qualitative approaches with the underlying assumptions of my research moving from a more 'objective' to a more 'subjective' view of reality. Initially, I found this shift difficult but as I became familiar with the use of qualitative approaches in research and work, my ontological view changed accordingly.

My previous research work in primary care (Wiener-Ogilvie et al 2007; Wiener-Ogilvie et al 2008) emphasised the role that team work and interprofessional relationships have in determining patient care. This work has influenced my view on the way work is organised in primary care and may have inadvertently influenced my

interpretation of the current data. Nevertheless it is argued that all qualitative researchers inevitably bring their own world view to bear on their research (Gibbs 2007).

My role as an Associate Adviser in the South East Deanery enabled me to acquire considerable understanding of the broader issues that concern GP trainees during their training and of the environment in which they are expected to work and learn. Despite not being a doctor or a GP myself, I felt well informed about General Practice training and was familiar with the language and terminology used by study participants.

3.5 Methods

3.5.1 Consideration of methods

In developing my research design, I considered applying various methods. One method I could have used to explore the research questions was the case study approach as outlined by Yin (2003) and Merriam (1988). Merriam 1988 (p9) described a case study as *'an examination of specific phenomenon such as program, an event, a process, an institution or social group'*. Case studies are focused on a particular context and data collection occurs in the real environment. They provide rich descriptive data, using a variety of sources-direct observation, interview and examination of documentation (Merriam 1988). In the context of my research questions, a small number of Practices could have been chosen as case studies with observations and interviewing of trainees, trainers and others involved in the teaching of trainees.

A number of difficulties could, however, have arisen with this approach. First, it would have been difficult to determine a sampling strategy - what is a typical training Practice and which Practice is atypical? Secondly, on the practical side, gaining 'entry' into GP Practices may have been difficult for someone not working there. Watching GPs at work requires patient consent. In addition, the whole Practice would need to agree to take part in the research and as training Practices are often

large, it might have been hard to reach consensus and agreement. Finally, the research questions aim to explore the perceptions of trainees rather than of those working with them. Accordingly, I felt a case study was not the most appropriate method.

The questions could have been also explored using an ethnographic study. Ethnographic research aims to describe the values and beliefs of cultural groups. Its assumption is that one learns about a culture from the people who live in that culture. This requires an ongoing involvement with participants and data are collected via observations and in-depth interviews (Ploeg 1999).

To answer my research questions, I could have conducted observations of GP trainees within their training Practices. There are however, some limitations and practical obstacles in using this approach in the context of my research questions. First, observation of interactions between, on the one hand, trainees and, on the other, trainers, other GPs and the extended multidisciplinary team within a specific General Practice setting, could not have provided an in depth description of how GP trainees view their training environment in General Practice. Rather it would have provided an interpretation of what the researcher saw during observations. Although observations could have been supplemented with interviews with trainees, I felt this approach was not optimal in answering the research questions. Second, this approach would have not enabled me to gain perspectives from early career GPs who have already completed their training and left their training Practices. Finally it would have been difficult to gain access to conduct observations in a large number of training Practices due to various governance mechanisms.

Following consideration of alternative methods, the primary method chosen for this study was in-depth, semi-structured interviews with GP trainees and early career GPs. The study design including sampling strategy will be described in more detail in section 3.5.2. I chose to examine the perspectives both of those currently in training and of those recently qualified. Clearly, the perspective of those currently in training is important in understanding how they perceive their training environment

whilst they are still in training but it is also valuable to explore the perspective of those who have completed training as they can reflect on their training environment in the context of their current workplace demands.

I consider that there were advantages in conducting one-to-one interviews with a number of trainees and early career GPs as opposed to the other possible methods described above. First, as previously mentioned, it would have been impossible to gain the perspective of early career GPs via ethnographic or case study methods. Second, my approach enabled me to explore the experiences and reflections of interviewees who trained in different and varied GP training Practices. It allowed me to explore whether there were themes or threads common to the way these doctors described their training environments. In addition, by interviewing doctors who worked in various settings, I was able to gain an understanding of the different training environments and the way these shaped both trainee's experiences and their perceptions of preparedness.

3.5.2 Study design

In-depth, one-to-one, semi-structured interviewing was the primary method used in this study. Face-to-face interviews, 22 in total, were conducted. In addition, five telephone interviews were carried out with participants with whom it was difficult to arrange face-to-face meetings because all were at a considerable distance from Edinburgh, some in remote and rural locations. All interviews were recorded and transcribed verbatim.

I had intended to conduct approximately 40 interviews, each lasting approximately 45 minutes. In the event, interviews took longer than anticipated (averaging 69 minutes and ranging between 45 minutes to an hour and 40 minutes) because the majority of participants became heavily engaged and reflected in depth on their experience. As data collection was accompanied by data analysis, it became apparent that data saturation was reached after 24 interviews. I conducted 3 additional

interviews to ensure that no new codes emerged. The process of reaching data saturation is further explained in section 3.7.

Sampling strategy and recruitment

For newly qualified GPs

Trainees who completed training in August 2009 and 2010 in the south-east of Scotland were asked if they agreed to have their contact details held by NHS Education Scotland. A sample of which was contacted six months to 20 months following completion of their training and asked to take part in the study. The sampling framework aimed to include newly qualified GPs working in a variety of jobs: salaried doctors employed by Practices or by PCTs, GP locums and those working as GP partners. It also included newly qualified GPs trained in Practices with high or low deprivation indicators (often a good proxy for workload during training), as well as both immigrant and UK doctors, in order to provide a true representation of GP trainee cohorts. Other information, such as gender, ethnicity, age, years since registration, first language, place of medical school and details on completion of UK foundation programme for doctors, was also collected.

Newly qualified GPs were contacted via e-mail invitation, using the e-mail address they provided initially. Participants who completed training in August 2009 were sent an e-mail invitation in June 2010 and then again in November 2010. Participants who completed training in August 2010 were contacted in June 2011. To ensure recruitment into all aspects of the sampling framework, further individualized e-mail requests were sent to trainees who trained in specific areas. For example, individualized e-mails were sent to people trained in deprived areas and in medium-sized or rural Practices. Although initially I contacted only GPs trained in the south-east of Scotland, during the second year of recruitment (2011) I did contact trainees from other areas. I used local contacts in the north and west of Scotland to put me in touch with early career GPs in these areas. This was done primarily to satisfy such sampling requirements as the need to recruit trainees from more remote and rural locations but also to ensure a Scottish rather than a south-east Scottish perspective. I

also sought to recruit GPs trained in two Practices as well as those trained for 12 and for 18 months in General Practice. I felt it was important to explore whether training in more than one GP Practice or for a longer duration in General Practice, had an effect on perceived preparedness or on the training experience in general. All together 15 interviews were conducted with early career GPs, 6 months to 2 years post qualification.

For GP trainees

GP trainees in the final months of their training who had passed the two RCGP examinations (CSA and AKT) in the south-east of Scotland were asked to take part in this study. Trainees were contacted in June 2010 and 2011 approximately six to eight weeks prior to completion of their training.

Sampling strategy and recruitment were similar to those for newly qualified GPs to include trainees in Practices with high or low deprivation, UK and immigrant doctors. Other information, such as gender, ethnicity, age, years since registration, first language, place of medical school, details on completion of UK foundation programme for doctors and the length of time spent in General Practice placements, was also collected. Altogether 12 interviews were conducted with GP trainees.

Characteristics of participants

In total 42 doctors were invited to participate in the study (22 early career GPs and 20 GP trainees) of which 32 replied indicating that they were willing to take part. Five of which, either did not satisfy study criteria (for example did not pass college exam or were not working as GPs) or were not required as data saturation was achieved by the time they replied. In total, 27 doctors took part (15 early career GPs and 12 GP trainees) of whom 13 were male and 14 female and the average age was 31.2. Twenty two of the interviewees spoke English as first language while for 5 interviewees English was a second language. Nevertheless all were fluent in English. Tables 2 and 3 (p.77) provide information on participants. Table 4 (p.78) provides information on the characteristics of GP Practices participants trained in. Appendix 1 lists all interviewees, their characteristics and their Practice characteristics.

Table 2: Participants' medical school and completion of UK foundation programme

Medical School	England	Scotland	European community	Asian	African
Numbers	6	16	1	3	1
Foundation programme*	Undergone UK foundation programme	Pre foundation (SHO in UK)	No UK foundation programme	Equivalent to foundation	
Numbers	13	12	1	1	

* Foundation programme was introduced in the UK in 2005 with all doctors required to complete the programme before applying for specialty training. It is a two year programme which includes clinical placements in varied hospital specialties and is designed to familiarise junior doctors with the clinical aspects of different specialties and the UK health care system as a whole.

Table 3: Participants' length of GP training, time spent training in General Practice and time at interview since completion of training.

Length of GP training	Number	Time in General Practice	Number
2 years	5	12 months	20
3 years	22	18 months	7
Time at interview since completion of training	Still in training	Completed training 6 months to 1 year earlier	Completed training 1-2 years earlier
Number	12	12	3

Table 4: Training Practice list size and urban/rural classification (number of Practices in each category)

Practice list size/ location in accordance with Scottish Government rural classification 2011-12*.		Up to 5000 registered patients	Between 5000-7000 registered patients	Above 7000 registered patients
Urban	Practices located in ‘large urban areas’ and that primarily serve populations from these areas.	0	2	13
Semi-urban	Practices located in ‘other urban areas’ (who also serve populations in ‘accessible rural’ areas).	1	3	3
	Practices located in accessible small towns (who also serve populations in ‘accessible rural’ and ‘remote rural’ areas).	1	1	0
Rural	Practices located in ‘remote small towns’ (who also serve populations in ‘accessible rural’ and ‘remote rural’ areas)	0	1	0
	Practices located in ‘accessible rural’ areas	0	0	0
	Practices located in ‘remote rural areas’.	2	0	0

*The Scottish Government (SG) Urban/Rural Classification provides a consistent way of defining urban and rural areas across Scotland and is based on population size and accessibility (Scottish Government 2012). It uses the following definitions to classify areas:

Large Urban Areas (with a population of over 125,000)

Other Urban Areas (with a population of 10,000 to 125,000)

Accessible Small Towns (with a population of 3,000 to 10,000 and within a 30 minute drive time of a Settlement of 10,000 or more.)

Remote Small Towns (with a population of 3,000 to 10,000 and with a drive time of over 30 minutes to a Settlement of 10,000 or more.)

Accessible Rural (with a population of less than 3,000 and within a 30 minute drive time of a Settlement of 10,000 or more.)

Remote Rural (with a population of less than 3,000 and with a drive time of **over** 30 minutes to a Settlement of 10,000 or more.)

I was unable to recruit participants from Practices located in ‘accessible rural areas’. This was because these areas are primarily served by Practices that are located in other areas (e.g. accessible small towns and remote small town)

Pilot studies and development of interview guide

The initial interview guide was developed following a literature review on workplace learning, professionalism in medicine and the concept of preparedness (outlined in Chapter 2). The guide is presented in Appendix 2 and includes 11 questions. The questions were designed to guide the issues covered in the interview and were not used in a prescriptive way during the interview. The interviewee was first asked to talk about their training Practice in general, after which further questions were asked about aspects of the Practice that were particularly good or less good for training and about the GP trainer. Interviewees were also asked about the meanings they attached to 'preparedness' and about aspects of the training Practice that were particularly good in preparing them. Although the interview covered all 11 questions, it was fluid enough for the interviewee so that questions were not always asked in the same order or using the same wording. Rather the guide was used to ensure that all topic areas were covered.

I sought through the interviews to see the world from the participants' perspective. I tried to 'enter' their 'world' and the situations they described. I did not question or doubt their perceptions but rather tried to gather a detailed picture of their experiences. In order to do so, I asked non-judgemental and open-ended questions that invited reflection on the experiences the interviewee described. I used questions like '*what do you mean by?*' or '*why do you think you felt that way?*' By reflecting back to interviewees what I thought they meant, I checked the accuracy of my interpretation.

After three interviews, the guide was slightly modified. Some additional background questions, a main interview question and three alternative questions were added. One question was removed as it was less useful in eliciting information (see Appendix 2). As data collection and data analysis went hand in hand, further sub-questions were asked in order further to explore identified issues (this process is described in more detail later). An example of an interview is given in Appendix 3.

3.6 Ethical considerations

I have followed the revised ethical guidelines for educational research published by the British Education and Research association (BERA) 2004. There was no financial incentive for participants. Ethical approval was sought from the Moray House School of Education Ethics Committee. As this research involved NHS staff, an additional full ethical approval application was submitted through the IRAS system and was considered by the South East Scotland Research Ethics Service. Ethical approval was granted by both of these research governing bodies (see Appendix 4). The research was also registered with NHS Education Scotland Research Governance System.

Merriam (2009) posited that conducting a research in an ethical manner is an integral part of the reliability and validity of qualitative research. She suggested ethical concerns in relation to qualitative research largely relate to the following issues: the protection of subjects from harm, the right to privacy, the notion of informed consent and the issue of deception-if exist.

Informed consent

All interviewees were given information on the study prior to the interview, which explained how the data would be anonymised and how it is would be used (see Appendix 5). I advised all participants that some of the anonymised transcript would be viewed by a group of educators for the purpose of developing an analytical framework and that quotes might be published in peer-reviewed papers. All interviewees signed a consent form indicating that participation was voluntary and that they were free to withdraw at any time. By signing the consent form, interviewees agreed that extracts from any written or verbal information, duly anonymised, could be quoted in any published material (see Appendix 6 for full consent form).

Confidentiality

Since one-to-one, in-depth interviews were conducted with all participants, there was the potential for disclosure of sensitive information (for example, concerning patient safety or professional misconduct). In order for participants to remain honest and open in their answers, it was important to ensure the anonymity of all those taking part as well as the security of the information given. I considered that there was a potential for an ethical dilemma if interviewees revealed any issues concerning professional misconduct (of themselves or others) particularly if related to patient care. Interviewees were reminded prior to the interview of their professional responsibility as doctors in regards to such matters. Fortunately in the event, interviews did not present such dilemmas.

Ethical consideration needs to be given also in regards to the Researcher relationships with the subjects. My work at the GP unit in the deanery is in the area of quality assurance of General Practice training. Some of the doctors interviewed were aware of my role while others, particularly those who did not train in the South East Scotland were not aware of my role. It was therefore pertinent to emphasise to participants that any information disclosed during interview would not be ‘acted on’ unless they chose to raise the issue through formal channels. The same applied to interviewees who had completed their training as some were still dependent on references from previous training Practices.

Protection from harm

Prior to conducting the interviews, I clarified with participants that any information disclosed remained confidential and would not be acted on. I advised interviewees that I could offer support should they have any issues they wished to take up formally and told them of the various avenues available (such as complaint to GMC, appeal to the Deanery). None of the trainees wished any issues to be followed up formally.

Coercion

I was careful not to put pressure on the doctors I approached to take part in the study. Invitations were e-mailed just once and I followed up only those doctors who chose to reply. Some of the doctors were aware of my roles and responsibilities within my department but most, not having met me before, were not influenced by personal acquaintanceship in deciding whether or not to participate. Overall I felt that not being a doctor or a GP trainer myself was advantageous in the context of the study as interviewees viewed me as taking a more neutral or impartial stance to their stories.

Data protection:

Measures were taken to ensure the security of the data gathered: (a) recorded interviews did not include any personal information about doctors, such as full names or locations; (b) once transcribed, all identifiable information was removed from transcripts (names and locations); (c) finally, all files were kept in password-protected folders. These security measures were taken in line with advice received from NHS Education Scotland Caldecott Guardian.

3.7 Analytical approach

Interviews were treated as giving ‘direct access’ to the meanings trainees attribute to the notion of ‘preparedness’ and to the ways they viewed their training environment. The analytical position was therefore ‘descriptive and interpretive’. Transcribed data from interviews were analysed using generic thematic analysis as recommended by Caelli (2003), drawing on frameworks described by Gibbs (2007) and Creswell (2007). Thematic analysis is an inductive process in which parts of the texts capturing the data are grouped under themes which represent ideas or concepts. Such themes can be inducted directly from the written text but their formation can be also influenced by prior reading of the literature.

The data analysis was also influenced by grounded theory as described by Charmaz (2006). I have chosen to draw on her approach as it has an interpretive nature which emphasises local diversity, multiple realities and complexities. Charmaz is somewhat less prescriptive than Glaser and Strauss (1967) who originally developed Grounded theory as a systematic strategy for the conduction of qualitative research offering methodological consensus and systematic strategies, which strengthened qualitative research credibility at a time when quantitative research gained dominance. Charmaz offers a less rigid approach and suggests that grounded theory should be used as a set of principles rather than a prescriptive package.

Charmaz sets out a number of fundamental principles of grounded theory research:

1. Simultaneous data collection and analysis.
2. Construction of analytical codes and categories from the data, not from preconceived hypotheses.
3. The use a constant comparative method, making comparisons during each stage of the analysis.
4. Emphasis on the development of new theories from the data rather than viewing the data through the lens of existing ideas on the subject. The literature review is therefore delayed in order to reduce its potential influence on the analysis.

In this study I did not use grounded theory as a primary method for conducting the research rather I drew on some principles of grounded theory during the analytical stage. Grounded theory is commonly used as a tool to examine social or psychological processes. Unlike grounded theory research, my own study was not initially intended to examine social or social psychological processes. Rather, my research questions were interpretive in nature: the intended purpose was not to examine the social process of becoming a General Practitioner but simply to obtain a description of how doctors view their training environment and of the meaning they attach to the notion of preparedness. Similarly, my initial intention was not to generate a 'theory' which is the ultimate aim of the grounded theory approach. I did

not, therefore, delay the conduct of a literature search around the research questions. On the contrary, I used the literature on workplace learning and preparedness to help me develop the interview guide. My analytical approach also deviated somewhat from the approach advocated by grounded theory: initial coding was not done line by line and did not convey action or feeling. As I read some literature prior to the conduct of the study, it is also possible that this knowledge has inadvertently influenced the formation of codes and themes. In addition, I did not employ 'focused' coding as advocated by Charmaz (2006) or formal procedures for axial coding as prescribed by Strauss and Corbin. The analytical approach used in this study is described in detail below.

3.8 Data analysis

All interviews were digitally recorded and transcribed verbatim (altogether 268,912 transcribed words). As suggested by Silverman (2005), this was done to enhance reliability as it enabled me to stay close to the data and therefore better interpret its meaning. I read and then reread the transcribed interviews, going back to recordings to obtain any necessary verifications.

The conduct of interviews and initial coding were undertaken in four cycles. First, I interviewed and coded interviews with three participants (first cycle). These interviews were treated as pilots and were used to check and refine the interview guide. In addition, by coding these initial interviews, I was able to look for ideas and gaps in the analytical process and to explore these with the next cycle of 10 interviews (second cycle). I continued this process, coding and conducting interviews simultaneously, refining interviews and exploring analytical gaps as a further five interviews were conducted and coded (third cycle), and then nine more (fourth cycle). The second and third rounds of interviews included more focused questions about relationships with trainers and about their feedback as the need to explore these aspects in more detail emerged from the coding of the first two cycles.

Initial Coding

I applied the Charmaz (2006) definition of coding: *‘coding is categorising segments of data with a short name that simultaneously summarises and accounts for each piece of data’* (Charmaz 2006 p43). Initially, I examined each sentence and attached a code to that sentence. At times more than one code was attached to a sentence, particularly in complex sentences where accounts could be summarised under a number of headings.

As advocated by Creswell (2007), I treated coding as an inductive process. I did not set a coding framework in advance but created the codes from the data. Contrary to Charmaz, I did not necessarily stay ‘close to the data’ initially, portraying only actions and feelings. Rather, as suggested by Gibb (2007), I tried to create analytical or theoretical codes as a way of explaining the data. I therefore coded the data under more abstract units of information, as I was looking for the implicit meaning of what was said. As new codes emerged, I went back to previous transcripts I had analysed to check that the new codes could not be applied to that text. This was done to address what Gibbs (2007) referred to as ‘definitional drift’.

As coding and data collection were carried out side by side, I was able to apply the ‘theoretical sampling method’ advocated by Charmaz (2006). As I developed codes, I continued to collect data in order to further develop these codes, elaborate their meanings, and examine variations and any possible links between them. It was, however, impossible deliberately to seek specific cases that illuminated certain themes as characteristics of the training environment were only revealed during interview. I continued to sample in order to achieve sufficient variation and depth. I also sought to include negative or deviant cases. I continued the process of data collection to include interviewees with a ‘positive’ training experience as well as those with a ‘negative’ one, those that had a positive relationship with their trainer and those that had a tense one and doctors with various degrees of difficulty during their training. All of these factors were deemed influential during the analytical stage. The inclusion of varied cases allowed me to explore how the content of the

codes varied between cases. The third and fourth cycle of interviews included doctors trained in rural areas and those that spent 18 months in General Practice. Again this was done to achieve maximum variation sampling, to include a broad range of perspectives as well as potential deviant cases.

In line with Charmaz, data gathering was stopped only when data saturation was reached, that is when gathering further data no longer sparked new theoretical insights or revealed new properties or codes. Finally once all interviews were coded, another medical educationalist colleague coded 2 interviews and compared his coding framework to the one I developed. Largely coding frameworks were similar and no significant amendments to the coding framework were required.

Once a list of codes was created, I reread the text included under each code. In this way I compared similarly coded texts to gain a deeper understanding of the meaning of that particular code. In addition, I examined how the same code varied from case to case (interviewee to interviewee). This technique is often referred to as 'constant comparison' and is recommended by grounded theory.

Second stage analysis

A second stage of coding was undertaken once all four cycles of interviews and initial coding were completed. Relationships between codes were defined and related codes were grouped under more generic themes. Any codes that were deemed duplicates (conveying the same idea) were combined. Unlike Charmaz, I did not focus on the most frequent codes to categorise the data (focused coding) but rather most codes were assigned a theme.

Throughout data collection and analysis, I used memos to capture any thoughts or ideas I had. I wrote a memo in narrative form after each interview to capture my initial thoughts, contextual factors and the main issues I felt at the time had arisen during the interview. I also used memos to describe codes and later themes in more detail and to note any possible relationship between codes. In this way, memos assisted the move from initial codes to themes. I also used memos to make

comparisons between cases. Memos enabled me to reflect in more depth on the codes and themes developed and on the meaning I was creating, as well as on the influence of my own position on the process.

Third stage: re-examination of themes

I used Pope et al (2000) suggestion of deriving an interpretative framework for presenting the results by finding associations and connections between the different themes in line with the research questions. Once all data were coded and themes defined, the developed themes and supported texts were shared with a group of medical educationalists. The purpose of this exercise was to check for agreement for emergent themes, to debate possible linkages between these themes and to develop overarching categories and constructs.

Nvivo software was used throughout the data analysis to manage data and to create codes, themes and memos. This was a useful way for managing the large amount of text generated in this study.

3.9 Quality of the research

Validity and reliability are terms commonly used in the positivist paradigm to evaluate quality of quantitative research. Silverman (2005), who maintained that validity is another word for ‘truth’, suggested that there are no golden rules to establish validity and reliability of qualitative research. Similarly, Denzin and Lincoln (2003) suggested that although different criteria are proposed to define quality of qualitative research, in practice such criteria all aim to assess the research in terms of its ability to generate theory, its credibility, its ability to produce findings that are transferable to other settings and its reflexive nature i.e. the consideration of the effects of the researcher and the research strategy on the findings presented.

Lincoln (1985) argues that in qualitative research, the concept of validity should be substituted by 'authenticity', while Miles and Huberman (1994) advocate the use of the term 'trustworthiness' to describe the quality of qualitative research instead of 'reliability' and 'validity'. 'Trustworthiness' relates to the dependability, credibility, transferability, and confirmability of the research findings. I will use the framework suggested by Miles and Huberman to illustrate the quality of the research presented in this thesis:

Dependability relates to the provision of clear and transparent accounts as to how the data were collected and analysed (Merriam 1988; Flick 2006). To enhance the dependability of this study I presented a detailed account of the way data were collected, the analytical approach used and steps taken during the data analysis (as outline in sections 3.5.2 and 3.7-3.8).

Credibility refers to whether others can identify with the study findings or in other words the internal validity of a study. A number of approaches were suggested to enhance credibility. Merriam (1988) suggested that credibility can be strengthened by triangulation of multiple sources and by validation of findings with participants. Similarly Silverman (2005) proposed that the validity of qualitative research can be enhanced through 'respondent validation' where the researcher goes back to the subjects with the preliminary results and refines them accordingly. Nevertheless, Silverman argued that this approach is not invariably necessary as it implies that the researcher assumes a privileged status to respondent account which may not be appropriate. In this study, I used the 'respondent validation' approach. Once the analytical framework was completed, I presented the findings to a group of GP trainees at the final stage of their training as well as to a group of postgraduate medical educators. Feedback from these two groups was used as a form of triangulation.

Credibility of a research is also suggested to be gained through comprehensiveness with all data incorporated into the analysis and to be enhanced by deviant case

analysis where alternative explanations are sought to explore a particular phenomenon (Merriam 2009).

Another method for establishing credibility suggested by Silverman (2005) is the 'refutability principle' by which the researcher seeks to refute assumed relationships within the phenomena. Only if these cannot be refuted, can the researcher assume objectivity and claim validity for findings. Silverman advocated the 'constant comparative method' in which the researcher seeks yet another case to test any provisional hypotheses or moves from small to larger data sets to test hypotheses. This method is not dissimilar to the method employed by grounded theory which seeks constant comparisons within the data and identification of deviant cases (Charmaz 2006). I attempted to use this method by recruiting varied interviewees and by comparing experiences and descriptions of different interviewees throughout the data analysis process (see section 3.8).

Transferability relates to the extent to which the findings of the research can be applied to other situations or contexts (Lincoln 1985). The extent to which the findings are transferable can be determined through the provision of 'thick' and 'rich' descriptions which I am intending to provide in Chapters 4-6. Transferability can be also enhanced by the inclusion of variation in the study sample. As described in the section 3.5.2, I paid careful attention to the characteristics of the interviewees and their training Practices when selecting cases to the study and sought particular cases (such as doctors who trained in rural Practices , immigrant doctors etc) in order to achieve maximum variation in the sample.

Confirmability -interpretive research acknowledges that the researcher will influence to some extent the findings of the research through interaction with participants and during data interpretation. Confirmability can be enhanced through the acknowledgement of any research biases by the provision of a clear outline of any personal interests of the researcher which may introduce bias. I attempted to do this by describing my own ontological position and work in section 3.4 and by explaining my motivation for conducting the research in section 1.1. The use of multiple researchers in the interpretation of data is also suggested to enhance confirmability.

As outlined in section 3.8. I have involved other educationalists the development of themes.

Application of the research findings is viewed as another reflection of the quality the research. Application of the research findings may however take time and is often dependent on the extent of the dissemination of the findings. The applicability of the study findings will be discussed in Chapter 8.

3.10 Summary

The research was informed by the interpretive paradigm. I used one to one semi-structured interviews with GP trainees and early career GPs to answer my research questions. Interview data were transcribed verbatim and analysed using thematic analysis and drawing on grounded theory approach. Issues relating to the trustworthiness of the study were addressed by the provision of a comprehensive picture of the intent of the research, the background of the researcher and the way in which the research was conducted including case selection and the analytical approach used. Ethical issues were also considered and approaches for data protection, confidentiality, protection from harm and minimisation of coercion were outlined.

3.11 Introduction to findings

Chapters 4-6 present the findings of the study while the interpretation of the findings, in light of published literature, is considered in Chapter 7. The findings are presented in line with the research questions. Figure 1 provides a schematic representation of the way the findings are outlined in the Chapters.

Chapters 4 and 5 answer the first research question: ‘How do General Practice trainees and early career GPs describe their training environment in General Practice?’ Two broad constructs emerged: ‘The training environment in General

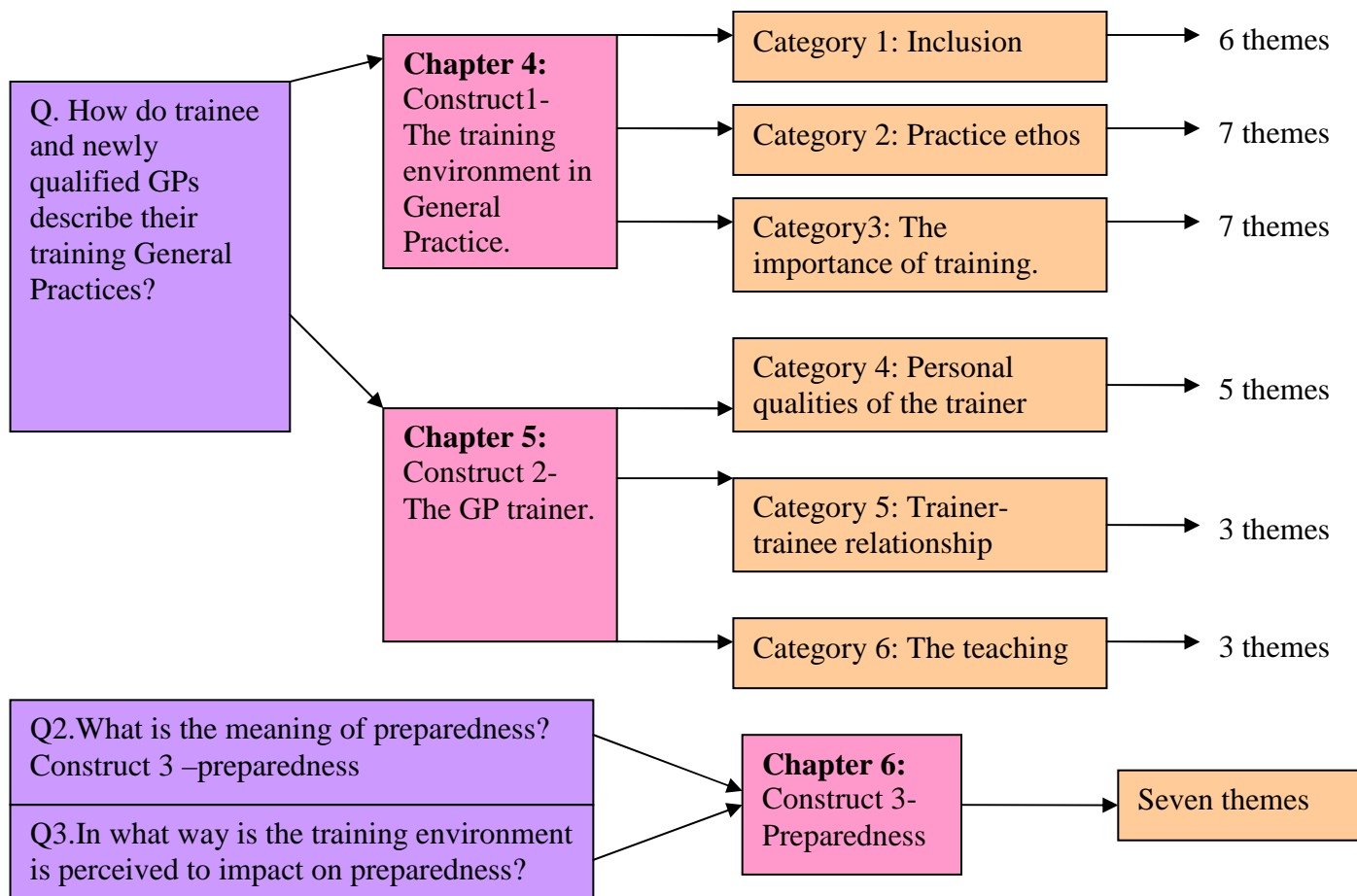
Practice’ and ‘the GP trainer’. Chapter 4, which deals with the first construct, presents three main categories arising from the data, namely, ‘inclusion’, ‘Practice ethos’ and ‘the importance of training within the Practice’, as well as their related themes. Chapter 5 outlines three main categories, relating to the second construct, namely, ‘personal qualities of the trainer’, ‘trainer-trainee relationship’ and ‘the teaching’, plus their related themes.

Chapters 4 and 5 begin with an introduction to the way themes and categories were developed. There is an overview of each construct, with summaries preceding category descriptions and shorter précis boxes for the themes. Bullet points sum up the main issues at the end of each category.

Chapter 6, which answers the second and third research questions, describes the meanings that trainees and early career GPs attach to ‘preparedness for Practice’ with preparedness presented as a third construct with seven underlying themes. Drawing on the themes identified in Chapters 4 and 5, the Chapter outlines the way in which trainees and early career GPs perceive the impact of their training environment on the seven underlying themes of preparedness. An introduction to preparedness and an overview of the themes are included. A précis box precedes each theme and bullet points close the Chapter.

As all data were anonymised, pseudonyms are used for all quotes. Transcription is verbatim, with only minor editing to assist legibility. By and large, there were no differences between the GP trainee (GPT) and the early career GP (ECGP).

Figure 1: Schematic presentation of the way the findings are presented in the Chapters.



Chapter 4: Findings- Construct 1- ‘the training environment in General Practice’

Introduction

Initial analysis of the descriptions by trainees and newly qualified General Practitioners of the training environment in their General Practices generated 106 individual codes (see Appendix 7). Further analysis (stage 2, outlined in Chapter 3, p.85) yielded 20 themes. These themes were grouped under three main categories, namely, ‘inclusion’, ‘Practice ethos’ and ‘the importance of training within the Practice’ as outline in Table 5.

Table 5: Construct 1- The training environment in General Practice: categories and related themes.

Category	Themes
Inclusion	Feeling part of the team.
	Valuing and respecting the trainee’s opinion
	Acknowledging and appreciating trainee’s undertaking of additional responsibilities or roles.
	Participation in meetings.
	Involvement in business- management
	Physical layout
Practice ethos	Hierarchy – hierarchical versus non-hierarchical nature of Practice.
	Progressiveness (openness to suggestions, learning from mistakes, forward thinking versus resistance to change).
	Team work
	Practice-patient relationships
	Relationships with Practice staff
	Relationships between doctors
	Orientation of trainee to the ethos of the Practice
The importance of training within the Practice..	Adaptation to the trainee’s learning needs
	Perception of ‘being used’
	Caring and Support for the trainee
	Approachability and commitment
	Supervision
	Having more than one trainer
	Organisation of work and its impact on training

Overview of Construct 1: the training environment in General Practice

Chart 1 (p.96) summarises the relationship between the identified categories and themes describing the training environment of a General Practice.

The degree to which trainees felt included within the Practice is covered by the first category, 'inclusion'. Feeling a part of the team derived from a variety of experiences such as being valued for their opinions and /or for undertaking specific responsibilities, participating actively in formal or informal meetings and professional conversations, and opportunities to be involved in business management. Practice layout and facilities affected opportunities for informal conversations and team work, which in turn influenced the sense of being 'included'.

As well as enhancing the feeling of being part of the medical team, opportunities to take part in professional conversations provided trainees with support, reassurance and a safety net, particularly when dealing with difficult patients or when making complex decisions. Informal meetings provided a platform to approach and discuss clinical cases with other doctors in the Practice, making them more accessible to trainees. The category 'inclusion' therefore relates to the themes of 'caring and support of trainee' and 'approachability' found in the category 'the importance of training within the Practice'.

The second category, 'Practice ethos', includes the themes of 'hierarchy' (hierarchical versus non-hierarchical nature), 'progressiveness' (the extent to which the Practice embraced change and had a culture of learning from mistakes), 'team work', 'relationships with Practice staff', 'Practice-patient relationships' and 'relationships between doctors'. Interviewees reflected on whether or not they shared the ethos of the Practice.

Practices which were described to be characterised by hierarchical relationships between doctors, particularly vis-à-vis trainees, were also described as non-progressive' and as having a lesser emphasis on team working. Hierarchical

relationships reduced opportunities for trainees to be involved in the Practice making them feel less 'included'. Conversely Practices which were described as non-hierarchical towards trainees were also described as more progressive. This involved, for example, a willingness to take up suggestions, a culture of learning from mistakes and a forward-thinking attitude. Such Practices tended to have a team work ethos which facilitated the inclusion of and support for trainees through sharing information about patients and providing opportunities to participate in professional conversations. In these Practices, trainees were able to play an active role in decision-making and felt included. The themes 'hierarchy', 'progressiveness' and 'team work' therefore relate to the theme 'inclusion' as illustrated in Chart 1.

Practices with strained relationship with their employed staff, tended to have a more hierarchical set-up, including them to a lesser extent in decision-making and discussions. Practices inclusive of staff also tended to be inclusive of trainees. The themes 'relationship with Practice staff', 'hierarchy' and 'inclusion' are therefore interconnected as illustrated in Chart 1.

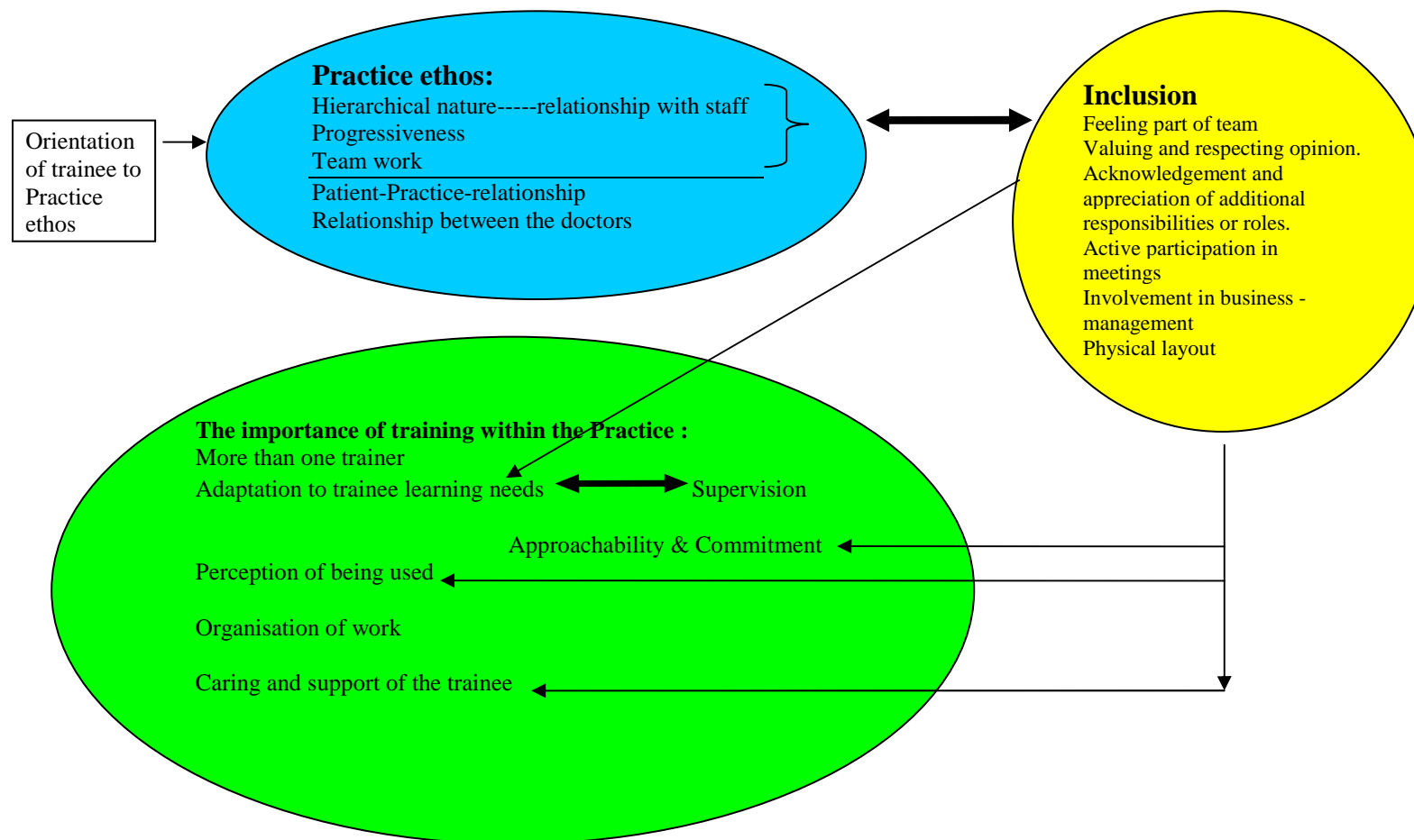
Practice ethos was also illustrated in the tension between patient needs and Practice business needs. GP trainees observed the tension between the wish to address patients' needs and the requirement to earn money. The relationship between the Practice and its patients was also a reflection of the Practice ethos. The nature of the relationship between the doctors in the Practice and how they worked as a team were additional themes reflecting that ethos.

The final category describing the training Practice was 'the importance of training within the Practice'. A number of themes were related to this category, namely, 'adaptation to trainee's learning needs', 'perception of being used', 'caring and support of trainee', 'approachability and commitment' 'supervision', 'having more than one trainer' and 'organisation of work and its impact on training'.

There was evidence that Practices described as inclusive of trainees, more readily adapted trainee's work to address their individual learning needs by, for example by

adapting rotas, workload or tutorial content. The theme 'inclusion' therefore relates to the theme 'adaptation to trainee's learning needs'. In such Practices trainees were less likely to perceive that they were 'being used' by the Practice and were better supported particularly in dealing with adverse events, with doctors and staff all being approachable. The themes 'inclusion therefore relates to the theme 'perception of being used', 'caring and support' and 'approachability'. Finally, it was also suggested that when a Practice invested in having more than one trainer, this was seen to reflect a commitment to training. The way work was organised in the Practice also affected learning opportunities.

Chart 1: Relationship between the identified categories and sub-themes describing the training environment in a training Practice



4.1 Category 1: Inclusion

Summary of category 1: 'inclusion'

In describing their training Practices, interviewees reflected on the extent to which they felt 'included'. The feeling of 'being part of' was a major characteristic of a positive training environment. The perception of being included was derived from a variety of experiences and is described in a number of themes: 'feeling part of the team', 'valuing and respecting trainee's opinion', 'acknowledging and appreciating trainee's undertaking of additional responsibilities or roles', 'participation in meetings', 'involvement in business-management aspects of General Practice' and 'physical layout'.

'Feeling part of the team' was explicitly referred to by a number of interviewees. Acknowledgement of and respect for the trainee's opinion denoted inclusion. When trainees were allowed and agreed to assume special responsibilities (for example, teaching or specific clinical duties) and when these were acknowledged and appreciated by the Practice, the result was a sense of being included and valued.

A further reflection of the extent to which trainees were included was their participation in informal or formal meetings. Such participation provided opportunities to see how partners worked together, how disagreements were negotiated and how staff were managed. Trainees could observe the role of, as well as the difficulties associated with, the non-clinical aspects of General Practice, which shaped their expectations of future employment. Sharing information helped trainees in dealing with complex patients.

Informal meetings, in particular, provided opportunities for GP trainees to discuss uncertainties relating to patient care. Such meetings provided a platform for professional conversations with other doctors which in turn exposed trainees to different views, opinions and approaches to clinical or risk management and enabled them to deliberate and form their own professional judgement or approach. It also demonstrated to trainee that learning is an ongoing and an integral part of General

Practice. Such opportunities also had the added benefit of making trainees feel ‘part of the team’ as learning was a reciprocal process.

Finally, informal meetings enabled doctors in the Practice to develop a personal rapport with the trainees, to understand their learning needs and to support them. They created a ‘breathing space’ for trainees and the rest of the team alike to unwind, reduce stress and diminish social isolation. Absence of meetings or lack of participation reduced opportunities for learning and support.

The findings, however, also suggest that the benefits of participation depend on the nature of the Practice and on the way meetings are conducted. In hierarchical Practices, where trainees’ active involvement in discussion was discouraged, attendance was less beneficial. Similarly, informal meetings were less useful when the time available had to serve competing agendas.

Inclusion of trainees in business or partners’ meetings was often presented as a separate issue. Inclusion in such formal meetings enabled them to learn about the business aspects of General Practice and made them feel more included in the Practice. Finally, it was suggested that the physical layout of the Practice can affect the integration of the trainee.

4.1.1 Theme 1: Feeling part of the team

Précis:

Interviewees talked about the extent to which they felt part of the team. ‘Feeling part of the team’ was an essential element of a positive training experience.

In describing their training Practices, interviewees talked about the extent to which they felt ‘included’ in the Practice. The term ‘inclusion’ originated directly from the ‘raw data’ as the quote from Kay (GPT) illustrates.

*‘I think just being part of the team is how they have done that you know they just **included** [emphasis] me as another doctor and not someone who is asked to do anymore or any less.’*

A feeling of ‘being part of the team’ was a motivating factor. Kay describes how she wanted to work harder in order to contribute more to the team and become part of it.

Kay (GPT)

*‘I think the **most** important thing was the team work and **being** made to feel like part of the team and so that made me want to better myself so that I would be kind of a useful part of that team. As soon as I started, I saw how they all functioned together, I saw how well they all interacted and how much initiative they all took, and I just wanted to be part of that, so for example, I was dying to get down to 10 minute appointments so that I could do the same as everybody else.’*

On the contrary, John (ECGP) trained in two Practices, one of which was a large Practice where he did not feel part of team:

‘I was seen as a registrar...in the Practice, yeah...but not really as part of the Practice, which I think is the weakness of the large Practice and I was seen more like a...like a....helping hand rather than a trainee...’

4.1.2 Theme 2: Valuing and respecting the trainee’s opinions

Précis:

The extent to which trainees felt comfortable voicing their views, and thought that these were valued and respected was also frequently commented on. Feeling that their views were valued and respected was an indication of an ‘inclusive’ training Practice.

Allowing trainees to ‘have a voice’ and to have their views aired and respected was reported as a positive aspect of a training Practice and as an indication of the trainee’s value to the team. Such an approach enhanced self-value, as Grant and Alex explain. There was evidence that such opportunities often evolved over time, the longer the trainee worked in the Practice.

Grant (ECGP)

‘They respected what I said – if I gave an opinion on something, however trivial, they would take it on board and take it seriously and they were really respectful of me as part of the team. I felt more and more part of the team as I went on until

the very end when I did feel almost an equal – they were that respectful of my opinion.'

Alex (GPT):

' They are happy to take on board if you think that things could be done better, they are happy to listen to you and...um, I mean certainly they say 'Thanks very much, that is interesting, I've learned something', so they kind of make you feel quite positive about yourself as well.'

4.1.3 Theme 3: Acknowledging and appreciating the trainee's undertaking of additional responsibilities or duties

Précis:

Assigning additional responsibilities to trainees was viewed positively and as an indication of being 'included', particularly if appreciated and acknowledged by the Practice. Trainees viewed being given additional responsibilities as a reflection of trust in their abilities which resulted in them feeling valued members of the team.

A number of interviewees talked about being trusted, valued and appreciated for taking on additional responsibilities. For example, Erica (ECGP) was responsible for an area of QOF in her Practice, Sabil (GPT) looked after nursing homes and Kay contributed to the patient newsletter and to research in her Practice.

Fatima (ECGP) talked about teaching medical students in her Practice:

'And it just sort of, made me feel appreciated and valued that they thought... And they always asked me my permission before they arranged the tutorial, you know I was happy to contribute.'

4.1.4 Theme 4: Participation in meetings

Précis:

Participation in informal meetings and professional conversations enabled other doctors to get to know the trainee better and facilitated the feeling of being included and supported. In addition, participation in formal and informal meetings provided excellent learning opportunities. It enabled trainees to gain insight into and understanding of partnership dynamics and to see how conflicting opinions between partners and issues concerning staff management were negotiated. Participation in formal and informal meetings provided a platform for professional conversations with doctors which in turn exposed trainees to different views, opinions and approaches to clinical or risk management and enabled them to deliberate, form or legitimate their own professional judgement or approach. Trainees shared their own views so that learning was a two-way process between them and the other doctors in the Practice. This illustrated to trainees that learning in General Practice is ongoing and that even experienced GPs have uncertainties about clinical management. Nevertheless, participation in meetings was less valuable in Practices of a hierarchical nature.

Informal meetings facilitated the integration of the trainee into the Practice team. It was clear that protecting time for such activities reflected an emphasis on mutual support as part of the Practice team approach. In addition, it provided opportunities for doctors in the Practice to get to know the trainee, both on a personal level and in terms of learning needs. This then enabled the Practice to tailor support to the needs of trainees. Informal social interaction facilitated a perception of personal support and a feeling of liberty to ask questions. These were illustrated in a number of accounts, for example, by Oliver and Pamela.

Oliver (GPT)

'I thought it was great (informal meetings), it let me be a part of things very quickly so I was part of conversation and part of that group and that group discussion. It probably let me feel part of things quite quickly not feeling like I was some little trainee in my own little room somewhere but I was one of the, one of the team.'

Pamela (ECGP):

'And I think you also start building relationships with these people, that if you went about your whole day in your room you would never build. And so therefore you have this kind of...emm...personal support which is kind of, it's subtle but you know it's there because you learn about the other people's lives and they learn about yours and so you feel supported as a person as well.'

'Yeah well I felt that they, they did understand me. I felt they actually had quite a lot of insight into who I was but also how I would deal with clinical situations.'

Interviewees expressed the extent of their inclusion in the Practice, when talking about their participation in meetings. These were either formal Practice meetings (weekly, multidisciplinary, business or finance) or informal coffee or lunchtime gatherings. It was evident that although format and content varied from Practice to Practice, all provided learning opportunities for trainees.

Participation in meetings, whether formal or informal, provided opportunities for trainees to see how the team resolved contentious issues and considered different views. For example both Kay (GPT) and Emily (GPT) reflected that taking part in Practice meetings enabled them to observe the dynamics of partnership, the resolution (or otherwise) of disagreements between partners and the making of decisions. .

In addition, participation in meetings allowed trainees to observe how the partners dealt with staff management issues. It enabled trainees to reflect on the management style of their Practice. For example Gerard, (GPT) commented on the 'top down approach' of the partners in his practice towards employed staff which he detected while taking part in meetings. Participating in meetings therefore enabled Gerard to reflect on his own views as to the style of partnership he wished to work in, thereby shaping his perspective on future employment:

'It is a system thing now...um...you do have.. The partners are the bosses which I guess they actually always are but in a particularly top down approach it seems like the staff find it difficult to actually say ' We really don't think we should be doing that' or 'We don't think that's appropriate' because they've got into that habit and that system'

'And certainly it has – as you say – it's given me food for thought for what I will look for when I leave and what style of environment I want to work in and partnership and things.'

Meetings provided opportunities for the team to share medical as well as social information about patients with the trainee. Meetings, particularly when informal (during coffee breaks or lunch breaks), provided a platform for professional conversations with other doctors and fostered discussions of uncertainties in relation to patient management. These not only provided learning opportunities (in terms of learning about different approaches to clinical management or about services availability) but also enabled trainees to see that doctors at all levels can learn from one another. In such informal discussions, learning was often a two-way process between the trainee and other doctors. Seeing doctors discussing their own uncertainties or seeking advice and information from one another was reassuring to trainees as they learned to recognise that learning was ongoing and that even experienced doctors have uncertainties.

Grant (GPT) described the usefulness of informal learning and the realisation that learning in General Practice is ongoing.

'Everyone in the course of the morning would have seen something tricky or would have some sort of question to ask about 'has anyone seen this, that or the other?' or 'has anyone used this for this?' or 'have you seen this particular patient and how did you find that problem?'. And everybody was really good about saying 'oh yes, I've seen that person before and I've done this that or the other with them' or 'I've seen a similar case and I've done this' or 'there's a local service available and I've found it really useful and this is how you use it or tap into it'. You know, that kind of informal discussion can be really useful.'

'Yes, and the other good thing is that you see that GPs of 10 years are still asking questions of each other and it's really reassuring to see that it's not just you that has the constant uncertainty of what you're up to or what do you do.'

Being part of discussions enabled trainees to see that there are different approaches to clinical care and risk management. It provided opportunities for trainees to consider alternative approaches and to form their own views. Pamela (ECGP) explained how informal professional conversations with different doctors in her Practice allowed her to gain different perspectives on clinical management:

'And you might get the opinion of one person but you might get the opinion of two people...'

'Because you do...start to get to get a feel for how they practice as doctors and their views on things...and the sorts of things they would be concerned about and the sorts of things they wouldn't be.'

Andrew (GPT) described how participation in meetings enabled him to consider partners' contrasting approaches toward risk management., which were all mutually respected:

'One of the partners, who has been there the longest, I feel that he seems to have an attitude more of that people should be taking a bit more responsibility. The other partners generally are a bit more, you might say, left wing or a bit more...I don't know...um...willing to take on more things. But it doesn't cause a tension really.'

Having considering the different approaches, he then formed his own view.

*'You really do need to take on that responsibility. I think that **is** right, though. If you're working with a vulnerable population, that's part and parcel of the work that you're doing.'*

Trainees valued the approach of 'learning together'. Being able to contribute to professional discussions increased self value and made them feel part of the team.

Sara (ECGP)

'And I think you're more part of the team when everyone talks together rather than it being, 'That's your room. That's your work. Get on with it.' I think you feel more valued as... when you're part of a team and when there's coffee mornings. I think that's quite important.'

Meetings also provided opportunities for trainees to make their views heard and to discuss issues relating to their training. In addition, they provided an arena to reflect, reduce stress, unwind and reduce isolation which in turn increased confidence.

Eleanor (ECGP) talked about the opportunities for informal professional conversations.

'It provides you with that kind of extra bit of confidence in that you know there are other people around there if you need a bit of help. You're not solitary working which is one of the things that is challenging about General Practice.'

Not attending informal meetings was seen as a missed learning opportunity by, for example, Barbara (GPT) who worked in a Practice where informal meetings rarely occurred. It also reduced opportunities to support the trainee (this was demonstrated in Eleanor's account). Exclusion of trainees from business or management meetings further reduced opportunities to learn about Practice management and partnership dynamics (these were demonstrated in both Eleanor's and Felicity's accounts) and made the trainee feel excluded from the rest of the team.

However, participation in meetings was not always a valuable experience. Judith (ECGP) suggested that meetings in her Practice did not maximise learning opportunities for trainees as they did not facilitate discussion of patients or of significant events. In addition, in Practices of a hierarchical nature, participation in meetings was viewed as less valuable and even frustrating as opportunities for trainees to contribute to decision-making or to have their opinions listened to and considered were limited. Samuel (GPT) reflected on the differences in the nature of informal meetings in the two different Practices he trained in. He felt that it was less acceptable to share uncertainties during coffee breaks in the Practice which was characterised by hierarchical relationships between doctors.

'I think it's fair to say that it still did happen (informal meetings in Practice X)...er...and I think in the other Practice (Practice Y) people would share uncertainties about particular patients or concerns about particular patients at coffee time and they (Practice x) were actually better at making sure everyone was there at coffee time every day – they were quite rigid about that. Um...but I suppose..um...yeah, I did think there was as much of a feeling of, you know, everyone has uncertainties and everyone asks everyone, it was more ...er...you know, a GP who didn't know his patient as well would ask a GP who'd known them for longer..'

4.1.5 Theme 5: Involvement in business management

Interviewees described their involvement in business meetings. This aspect was more difficult to interpret as interviewees reported different types of meetings in which finance and business issues were discussed. For example, some Practices included business issues as part of normal weekly Practice meetings while others discussed them at partners' meetings only. It is beyond the scope of this study to describe these different mechanisms. However, it was apparent that the extent to which and the way in which trainees were involved in business management varied from Practice to

Practice. Being included in business meetings was viewed as important as it enabled trainees to learn about that aspect of General Practice.

Trainee's involvement was sometimes 'passive', for example, simply being informed by the Practice of developments (as described by Arvind) or observing business meetings (as described by Paul and Andrew). Others reported active participation in business or management meetings (Erica, Pamela, Samuel's second Practice, Emily Judith, Kay, John), with trainees taking responsibility for a particular management area, especially towards the end of their training year. In some Practices, trainees were not included in finance/business meetings and had little involvement in the business aspect of the Practice (Fatima, Gerard, Samuel, Sange, Oliver). Inclusion in business meetings was also viewed as a reflection of inclusion. However, there was an indication that in Practices of an inclusive nature, trainees were able to learn about business matters even without participation in meetings, for example, through informal conversations.

4.1.6 Theme 6: Practice physical layout

Précis

A number of interviewees suggested that the actual layout of the Practice affected opportunities for informal conversations and team work and therefore the integration of the trainee. Similarly, the availability of specialist clinics and the presence of the extended multidisciplinary team on the same premises were suggested to affect opportunities for liaison with these services. Having their own consulting room induced a feeling of 'ownership' while the proximity of the trainee's to the trainer's room was reported to be useful. Overall this theme was minor compared to the other themes discussed and did not generate as many comments from interviewees. However, the findings suggest that physical layout can affect the inclusion of trainees in the Practice.

In describing the Practice, interviewees reflected on the way in which the layout of the Practice affected opportunities for 'getting together' and for communication with other doctors (this was illustrated by Barbara and Oliver, both GPTs). Having a

communal area or a 'hub' where doctors congregate and check and discuss their mail was useful in providing informal learning and facilitating team work as Oliver explains.

'In terms of layout of this Practice it's quite important. They've got an open plan for the doctors which is brilliant...er...there's five or six computers and there's usually about six doctors in on any one day with the rota works and so lots of people will use a computer there for their admin and paperwork so there's a lot of conversation, a lot of asking questions, a lot of discussion and the district nurses would come in and catch you there to ask a question so it's a really, in terms of architecture and layout, really helpful, it's been really good, I think the Practice would be at a big loss without that. We have a lot of, there is a lot of, between the GPs there is a lot of rapport'

When other primary care services resided in the same premises, this eased access to the broader primary health care team. In addition, a number of interviewees talked about the availability of speciality clinics in their Practices, for example, minor surgery, travel and family planning. Nevertheless, having specialist clinics in close proximity did not necessarily result in trainees accessing these training opportunities. This will be further described in the category 'the importance of training within the Practice'.

Having their own consulting room produced a feeling of ownership and responsibility and reduced the inconvenience and stress associated with having to move rooms as Sange (GPT) describes.

'You have it all set the way you want. That's your room, it's your responsibility to look after it, there's a camera there, there's a TV available there, you can view video there.'

Similarly John (ECGP) suggested that not having his own room enhanced his feeling of not being part of the team while Kay (GPT) and Alex (GPT) both commented that it was useful to have their rooms next to the trainer's.

4.1.7 Key issues of category 1 – Inclusion

- Feeling part of the Practice team was a key characteristic of a positive training environment which was derived from experiences that made the trainee feel included (e.g. valuing trainee's opinion, taking additional responsibilities, participation in meetings).
- Participation in meetings (formal or informal) benefited trainees in the following ways:
 - It enabled them to learn about clinical and non clinical roles and responsibilities of a GP including partnership dynamics and management styles. This exposed them to the role and responsibilities they are likely to face in the future, thereby shaping perspectives for future employment.
 - It provided a platform for professional conversations with other doctors during which information about patients was shared and different approaches to clinical and risk management considered. This provided support, reduced stress, increased confidence in dealing with uncertainties or lack of knowledge and helped the trainee to reach an independent view. It also enabled trainees to recognise that learning was ongoing.
 - Participation of trainees in business meetings was indicative of inclusion particularly when active participation was welcomed. Learning about business was viewed as important in terms of preparing for future responsibilities.
 - The benefit of taking part in meetings was mediated by the nature of the Practice or the nature of meetings. Benefit was reduced in Practices with more hierarchical nature.
- Physical facilities and layout of the Practices were suggested to affect the integration of the trainee into the Practice.

4.2 Category 2: Practice Ethos

Summary of category 2- Practice ethos:

This section describes the category 'Practice ethos'. The ethos of the Practice was reflected in a number of Practice characteristics illustrated in interviewees' accounts. These were grouped under the following themes: 'hierarchy', 'progressiveness', 'team work', 'relationships with Practice staff', 'Practice-patient relationships' and 'relationships between doctors'

Practice ethos was reflected in the way interviewees described the hierarchical or non-hierarchical relationships within their training Practices, for example, between partners, employed doctors and trainees or between doctors and other employed staff. Practice ethos was also reflected in the progressive nature of the Practice that is the extent to which the Practice was open to suggestions, was willing to implement changes, had a culture of learning from mistakes and made consequent changes.

Interviewees also described the nature of team work amongst the doctors in the Practice. Poor team work limited support, information sharing and informal learning, and was often a result of strained relationships. Conversely, good team work facilitated integration accompanied by a feeling of inclusion.

The findings suggest that Practices described as less hierarchical were also described as 'progressive' and inclusive of the trainee with better team working amongst the doctors. In these Practices, there were greater opportunities for GP trainees to play an active role thus making them feel more included and allowing them to develop professionally. In addition these Practices more readily adjusted the type and level of work to suit the trainee's individual needs. The themes 'hierarchy', 'progressiveness' and 'team work' are therefore linked and relate to the theme 'inclusion' as Chart 1 illustrates.

Practice ethos was also reflected in interviewee's accounts of the relationship between the doctors and their employed staff. Practices that had less hierarchical relationship with their staff, tended to include them in decision-making and discussions concerning the running of the Practice. They were also inclusive of trainees. However, poor relationships between doctors and employed staff did not always affect trainees.

The nature of the relationship between doctors was also a characteristic of the ethos of the Practice. Poor relationships tended to affect training as they reduced opportunities for informal professional discussions, increased isolation and created an unhappy working environment. However, there was evidence that poor relationships did not always affect trainees.

The way in which interviewees described the relationship between the Practice and its patients (community involvement, commitment to patients and the continuity of care) was also a reflection of the Practice ethos. Training Practices that knew their patients well were able to better support trainees in managing these patients. The way in which training Practices balanced patient against business needs was also a reflection of their ethos.

The final theme describes the way trainees related to the Practice ethos. Not all trainees identified with the ethos of their training Practices, as will be further explored in Chapter 5.

4.2.1 Theme 1-3: Hierarchy, progressiveness and team work

Précis

The findings suggest that the themes ‘hierarchy’, ‘progressiveness’ and ‘team work’ are interrelated. Hence they are described here together.

Interviewees frequently ascribed a stratified or hierarchical relationship to their training Practices, as between partners, partners and salaried doctors or doctors and non-doctors. Training experience was mostly affected when the hierarchical relationship was between doctors (senior to junior partners or partners to non-partners).

The progressive nature of the Practice was also described in the extent to which Practices were open to suggestions, readily implemented changes and fostered a culture of learning from mistakes. While some interviewees noted that their Practices had a ‘progressive’ nature, fostering a culture where systems and clinical practice were constantly reviewed and improvements implemented, others reported a less ‘progressive’ nature. Interviewees also commented on the nature of doctors’ team work. Good team work facilitated the inclusion of the trainee and provided support. Poor team work had the opposite effect.

Practices that were viewed as less inclusive, progressive and hierarchical with poorer team working were described as rigid and unwilling to adapt to trainees’ learning needs by, for example, implementing changes to timetable and adapting the type of work trainees undertaken. In such Practices trainees were less able to play an active role in instigating and implementing changes. This restricted trainee’s professional development and made them feel less included and valued. Conversely, non-hierarchical Practices were seen to be progressive and collaborative, with inclusive working relationships democratic decision-making and good team work. There were opportunities for trainees to be involved, making them feel included and valued. The themes ‘hierarchy’, ‘progressiveness’, ‘inclusion’ and ‘team work’ are therefore interrelated.

‘Hierarchy’

Hierarchical relationships were identified at various levels: between partners (e.g. Samuel and Raj accounts), between partners, salaried doctors and trainees (e.g. Fatima, Gerard, Judith, and Eleanor accounts and Samuel’s account of his first Practice) or between doctors, nurses and administrative staff (e.g. Gerard and Erica accounts). Other interviewees described less hierarchical relationships: between partners (Kay, Pamela, Samuel’s second Practice), between partners and trainee (Alex, Kay, Emily, Erica, Geraldine, Kevin, Pamela, Samuel’s second Practice) or between doctors and non-medical staff (Kevin and Sabil).

For example, Fatima (ECGP) describes the hierarchical relationships she observed through participation in Practice meetings.

‘And you’d definitely be able to see that one or two of the partners had sort of more pull in making the decisions and the other two they definitely, their opinions were very much appreciated and taken into account, definitely. Then they would always ask the salaried GP, but the salaried GP you know, her opinion wasn’t as valued and taken on board as you know the partners’ opinions, although she does do the same amount of work it seemed as the partners.’

Erica (ECGP) describes less hierarchical relationship between her, as a training doctor, and the partners in the Practice.

‘I never felt there was some sort of hierarchy. I always felt there was more, I don’t know, more equality and that was again something that was very much different from hospital medicine where it is very hierarchical. You’ve got the consultants, then the registrar the Senior House officer. In the Practice we were much more equal. I thought that was a positive aspect as well.’

‘Progressiveness’

Interviewees commented on the ‘progressive’ nature of their Practices, that is, their willingness to adopt change and to try out new initiatives or approaches

Kevin (GPT) talks about the progressive nature of his training Practice:

'Rather than putting up barriers to things, they're very 'open minded' about doing new things and trying new things and testing them out. And equally if things prove to be ineffective, they'll stop doing it. But I think it's more the attitudes of saying 'yes' first rather than saying 'no' first and to do more things.'

The progressive nature of the Practice was also illustrated by a readiness to learn from mistakes and to implement changes as a result of significant events or audits. For example Sarah (ECGP) described how a significant event relating to child protection resulted in a system change in the Practice.

'And, you know, as a Practice as a whole, we've all learned from it and recognised where there were weaknesses. ... There's more a system change.'

The progressive nature of a Practice was also manifested in the extent to which the Practice encouraged trainees to implement their own ideas or suggestions, thus making trainees more involved in the work of the Practice. Kay (GPT) tells how she was encouraged to put forwards her suggestions.

*'I had a kind of suggested changes for Practice and I wasn't made to feel uncomfortable doing that at all, I was **really** encouraged that this was where we can improve in our prescribing.'*

Similarly she explains:

'So I kind of asked if I could do this research project looking at exercises in the population Practice, I was really encouraged to do that and they were really accommodating.'

Progressiveness was also illustrated in the willingness of Practices to take up new initiatives, with no financial gain to partners or in openness to ideas from external agencies.

Other interviewees reflected that their Practices were not 'progressive'. For example, Gerard explained that his Practice would only implement a suggested change if it was in the partners' interests and improved profits.

Team work

Interviewees reflected on the nature of team work within their training Practices. When describing teamwork, interviewees tended to refer to team work between the doctors in the Practice. Good team work was characterised by equal sharing of workload, equal share of areas of responsibility, common ethos and ways of working. For example Erica (ECGP) and Pamela (ECGP) both described how team work between the doctors was a key ethos, central to the functioning of their training Practice.

Good team work was deemed to be an effective way of working which resulted in an enjoyable working environment. It often meant that there were greater opportunities for informal and formal meetings with the team. This facilitated the inclusion of the trainee into the Practice team and provided support to the trainee as well as occasions for information sharing. Geraldine (ECGP) explains:

'It was important to feel part of the team. At the same time I knew if I was struggling I could get back-up.'

Similarly Kay a GPT describes how information sharing amongst the team provided opportunities for support:

*'We go through a palliative care list every Wednesday. So while we would be going through that list we would read up on the names and whoever was looking after them would kind of give a brief on how they were getting on and so everyone was **aware** of my patients and every now and again someone would say 'Oh how are you doing are you doing ok?''*

Poor team work, on the other hand, was described as a lack of mutual support or of work sharing or was characterised by the lack of a common ethos. It was often, but not always, a result of a poor relationship between doctors (e.g. Raj and Eleanor accounts). Nevertheless, Geraldine (ECGP) explained how the doctors in her Practice worked as a team on a day-to-day basis despite tensions between them. Lack of team work limited opportunities for professional discussion and the support offered to training doctors as Eleanor explains:

'They still don't meet for coffee, I think. Most lunchtimes, I ate on my own or with the receptionists ...I think part of the problem was the lack of informal meeting is that a lot of people would go away for lunch or be clearly caught up in other things and it was often very difficult to find someone'

Relationship between the themes 'hierarchy', 'progressiveness', 'team work' and 'inclusion'

The examination of data suggests that Practices which were described to be characterised by less hierarchical relationship, particularly towards trainees were also considered progressive - open to new initiatives, willing to learn from mistakes, forward-thinking and 'inclusive' of trainees (Arvind, Becca second Practice ,Grant , Erica, John, Kay ,Kevin, Oliver, Paul , Sabil, Sarah, Samuel's second Practice). Such Practices were characterised by good team working. Conversely, Practices which were described to have a more hierarchical nature were also considered to be less progressive-resistant to change and less inclusive (Samuel's first Practice, Fatima , Gerard, Barbara, Karen, Eleanor, Raj). Such Practices were described to have lesser emphasis on team working. The relationships between the themes 'hierarchy', 'progressiveness', 'team work' and 'inclusion' are illustrated in Table 6 (p. 118-121).

In addition, the findings suggest that Practices described as hierarchical and less progressive provided fewer opportunities for trainees to contribute to decision-making or to lead in implementing changes and improvements in the Practice. This was illustrated for example by Gerard's (GPT) and Barbara's (GPT) accounts outlined in Table 6 (p.118-121) and by Samuel (GPT) who explained that, having presented an audit of drug interaction which posed a clinical risk to patients in his first training Practice, he was made to feel uncomfortable for suggesting changes to prescribing arrangements. That lack of openness left him feeling undervalued and not a part of the team, restricting his ability to develop professionally. He explained how it was difficult for him as a trainee to be involved in introducing any change in the Practice because of its conservative nature, its resistance to fresh thinking and the fix role given to trainees.

'My experience of the Significant Event Analysis in the previous Practice was that they would often discuss things, but um, change was often actively resisted and, you know, ah, yeah, I didn't feel encouraged to move forward with any, sort of, my own ideas. I think just a sort of more conservative attitude of the Practice was more resistant to allow sort of fresh ideas and change to, to come in.'

'Um, so I think I felt as a trainee quite sort of undervalued in terms of how much I could contribute to the running of the Practice, because it just ran that way and, you know, they didn't seem that interested in new ideas or suggestions.'

There was also evidence that a hierarchical, non-progressive and less inclusive nature of a training Practice can impact on learning because the Practice less readily adapt to trainees' learning needs. Judith (ECGP) described how she felt disempowered to discuss her difficulties or her need to attend disease-specific clinics in her training Practice:

'I think sometimes you just don't feel that you're in that position because they've had trainees for years they are quite a notorious Practice for being a training Practice, they know what they're doing, you know, you're seen as being very fortunate if you get to train in that Practice.'

Similarly, Samuel (GPT) explained how the impact of the hierarchical relationship within his first training Practice meant that negotiating timetable changes to address his learning needs proved particularly complex, making it difficult for him to take charge of his own learning:

*'I didn't feel that there was a lot of response to feedback and to requests for changes in the way things were done...
If there were any changes going to be made to my timetable I would need to ask my trainer, who would often not give me an answer, but take it to a meeting with the Senior Partner to check that they were happy with it, and then would get back to me maybe a week or two later with a decision as to what I could do and what the conditions were, and so on.'*

By contrast Practices that were described to be characterised by less hierarchical and a progressive nature, more readily adapted work and support to the needs of trainees. Samuel (GPT) reported on his contrasting experience in his second Practice:

'In this Practice, when I ask if I can do something, um, my trainer just sort of looks at me slightly puzzled as to why I'm asking, and says yes, just go ahead, just re-arrange whatever you need to, and so I can move my personal study time to a different day so that I can attend a particular clinic, or you know, whatever I

feel is most useful for my education I feel, you know, trusted to manage my own learning.'

In these Practices, there were also opportunities for joint consulting, a marker for open, honest, trusting and equal relationships. This was illustrated in a number of interviews (e.g. Becca, Kay, Sange and Oliver). Oliver (GPT) explains.

*'but those were really helpful, those joint surgeries of me watching her and her watching me and I would give her feedback on what she'd done well and could do better and she would give me feedback on what I'd done and they were **really** useful... it was very big of her to open herself up to criticism from me.'*

Table 6 (118-121) outlines quotes from interviewees to illustrate the link between the themes inclusion, hierarchy, progressiveness and team work. It illustrates that Practices described as inclusive were also less hierarchical and progressive and were characterised by good team work among the doctors (see Geraldine, Kay, Erica and Sabil). Conversely Practices that were described as less inclusive were more hierarchical, less progressive and were characterised by poorer team work (see Gerard, Barbara, Eleanor, Samuel and Raj). The themes 'inclusion', 'hierarchy', 'progressiveness' and 'team work' are therefore interrelated as illustrated in Chart 1 (p.96).

Table 6: The link between the themes inclusion, hierarchy, progressiveness and team work

Interviewee	Perception of inclusion/	Hierarchy	Progressiveness	Team work
Gerard	<p>Not included: <i>Most of the partners' meetings we'll be there for a little bit but then they'll want to discuss things that they don't want to say in front of us. There are things that they do kick us out of the meetings for.</i></p> <p>Not encouraged to contribute to decision making <i>'I mean certainly as a trainee you don't tend to get asked your opinion that much in these sorts of meetings even with clinical...you know we're free to pitch in and offer thoughts but not really...we don't really get encouraged – nobody turns to us and says ' And what do you think ?'.</i></p>	<p>Hierarchical: <i>It is quite top down at the Practice, I mean, I think I would prefer to think that it was a little more – yeah – collaborative I think is probably the right word.</i></p>	<p>Difficult to initiate changes or new initiatives: <i>The partners don't tend to, if you like, encourage the salaried doctors to say 'I would like to start doing joint injections'</i></p> <p><i>'You would find it far more difficult to make that change within that Practice'</i></p>	<p>Work not shared between partners and trainees: <i>No, it's (the work) is not shared, it doesn't feel like a shared responsibility.</i></p>
Barbara	<p>Lack of inclusion in informal discussions: <i>It is interesting you never see them having a conversation you know they must have the odd question – oh god I saw this what would you do, or the odd, what can we do with this clinical dilemma do you think I should add this medicine or not, and you never see those conversations happening.</i></p> <p><i>When I first started there I lived much further away, so I used to stay for lunch and none of the other doctors eat there, so they all go away somewhere, I don't know where they go.</i></p>	<p>Hierarchical- separation between partner to staff and trainee: <i>Reception staff and nurses don't socialise with the doctors historically, and so the coffee times are at the same time so for me I will go and sit with the nurses and the receptionists and have a chat, for me that is normal, but I think historically that hasn't been the norm, so the opportunity just for pleasantries, what did you do at the weekend you know what are you up to tonight, what have you got planned for the festival, that kind of chat doesn't happen at all, it is business.</i></p>	<p>Resistance to change: <i>We had brought up how house calls get divided and things like that and that was discussed...He suggested a change that he thought would benefit our Practice, but it was basically, the change was not taken on openly as well, it is the only thing he has asked for, I suppose we should give it a try, it was quite openly, we have done it like this for 20 years, why does it need to change.</i></p>	<p>Lack of team work ethos: <i>They are very business like they work very efficiently.I just don't think they are friends.</i></p> <p><i>A lot of team work depends very much of just inside dynamics, who gets on with who and you know little snide comments made about people and things, you know I find that really uncomfortable.</i></p>

Interviewee	Perception of inclusion/	Hierarchy	Progressiveness	Team work
Eleanor	<p>Not included in meetings:</p> <p><i>I was aware of mechanism to solve disagreement but then of course I wouldn't have been involved in the actual partner meetings.</i></p> <p><i>Not really any involvement (in any initiative).</i></p>	<p>Hierarchical:</p> <p><i>And I have to say that the system that worked at xxx where you'd end up being divvied out lots of house calls and the salary doctors and the registrars got theirs first and the partners got them if there were any left. I'm not joking, that's exactly what happened. I hated it. It was, it felt like slave labour.</i></p>	<p>Not open to suggestions:</p> <p><i>There was a little bit of a feeling amongst the staff outside of the partnership that they couldn't really approach if there was worry or approach if there was something they were concerned about.</i></p> <p><i>They were not proactive in addressing their high home visiting rate:</i></p> <p><i>because of their visiting culture, I mean it's not unusual for them to have eight visits every day.</i></p> <p><i>it means massively re-educating patients and whether that's something that anyone would try and sort or whether it's accepted, I don't know.</i></p>	<p>Lack of support and teamwork amongst the doctors:</p> <p><i>If you were duty doctor (in current employing Practice) in an afternoon and you were absolutely stowed out, your colleagues would do a few calls for you, in a gap. That would never have happened in my training Practice. Never.</i></p>
Samuel	<p>Not feeling part of the team:</p> <p><i>I was asked, quite regularly asked, to leave, um, so that decisions could be made, you know in my absence and without my hearing about them, um, which made me not really feel part of the team.</i></p>	<p>Hierarchical:</p> <p><i>If there were disagreements, um, any decision was deferred to the Senior Partner and the more junior partners, um, wouldn't, um, ah you know, um, if they disagreed wouldn't sort of argue to go against the senior partner's decision,</i></p> <p><i>I think the trainee in the Practice has a fairly fixed role um, and there are certain things that are expected of you, certain things that you can expect of the Practice, um, and that relationship is fairly well established and not very open to change or challenge.</i></p>	<p>Resistant to new ideas:</p> <p><i>My experience of the Significant Event Analysis in the previous Practice was that they would often discuss things, but um, change was often actively resisted.</i></p> <p><i>No, no, so new ideas weren't generally too welcomed.</i></p>	<p>Partners not sharing responsibilities:</p> <p><i>There was a reluctance to make decisions without the senior partner being there.</i></p>

Interviewee	Perception of inclusion/	Hierarchy	Progressiveness	Team work
Raj	<p>Isolated not included: <i>It was very isolated. The only opportunity to get together was at morning coffee, and that was it. They did not work together or get along well. As a result I just had lunch at my desk too.</i></p> <p><i>They were never hostile to my suggestions but it seemed not much becomes of many people's suggestions.</i></p>	<p>Hierarchical (towards new partners): <i>You get new doctors with new ideas and it's unfair to just push them down all the time and not let them have a say.</i></p>	<p>Resistant to change: <i>Yes, changes to working structure or how you might accommodate patients were not received well, which is not right. It's not progressive.</i></p>	<p>Lack of team work: <i>The doctors weren't very happy in sharing the work out very well. If one doctor saw 2 patients one day they would only want to see one the next.</i></p>
Geraldine	<p>Included: <i>It was important to feel part of the team.</i></p> <p>Geraldine reports that she was included in all Practice meeting and was made aware of any disagreements</p>	<p>Less hierarchical towards trainee: <i>My trainer would emphasis that I would remember more about some things as I did exams recently. Rather than feeling like I was inferior and they were superior.</i></p>	<p>Proactive: <i>They were proactive and became outward looking.</i></p>	<p>Sharing of workload: <i>They had equal workloads. You were duty doctor for particular sessions. Some doctors took a bit longer to do some tasks but everyone chipped in.</i></p>
Kay	<p>Included: <i>I think just being part of the team is how they have done that you know they just included me as another doctor and not someone who is asked to do anymore or any less.</i></p>	<p>Non hierarchical: <i>They don't have a kind of divide between the partners and the salaried GPs which I think, I have heard about in a lot of other places, they all do same, they all kind of pull their weight.</i></p>	<p>Forward thinking : <i>They are always thinking about what they can do better, how the appointments are, looking at how many people we are seeing and the home visits and who sees what and that kind of thing, so I guess all those things together make them pretty forward thinking.</i></p>	<p>Emphasis on team working with extended team: <i>I guess it is just an extension of that good team work.</i></p> <p><i>The other thing I forgot to say actually is that talking about forward thinking, is in they kind of promote this kind of team working...they have had some meetings about how they want to complete the Investors in People Award, and they are doing that for the reception staff.</i></p>

Interviewee	Perception of inclusion/	Hierarchy	Progressiveness	Team work
Erica	<p>Included: I was, I was very included.</p> <p>Towards the end of the year I was definitely contributing more to the business meetings. Having opinions and that sort of things</p>	<p>Non hierarchical towards trainee:</p> <p>When I was in the Practice some of the partners were phoning me through as well. During surgery and asking me about things so I felt quite confident phoning them.</p> <p>You could give them informal feedback about patients or anything that you felt they had missed. I'd feel quite comfortable at my registrar Practice saying I think she has X, Y or Z going on..</p>	<p>Embrace chance and accept criticism from trainee:</p> <p>They were always amenable to changes with regards to drugs. They had regular meetings with pharmacies and they were always keen to have audit and audit the repeat medication and if someone had a suggestion about a change they would often try it if it was a better suggestion. They were always open to suggestions.</p>	<p>Good team working:</p> <p>They were quite supportive of each other and there was a good sort of team atmosphere in the surgery.</p>
Sabil	<p>Included: I wanted to feel that yes I was part of the team and not feel a trainee and lets ignore him act and I have to say I have been very lucky that the Practice where I worked they are wonderful people such a good team</p> <p>I used to feel really good, yeah, that they don't ignore my suggestions</p>	<p>Non hierarchical:</p> <p>And they would all meet up at the coffee time irrespective of who you are the doctors, the receptionist, the trainee so everyone knew who exactly they were from the cleaner and half an hour if they have any problem they were encouraged to discuss in that coffee meeting</p> <p>Everybody is important in that team and everybody's view is taken in to account.</p>	<p>Progressive, amenable to suggestions for change:</p> <p>So it was very good and my input was appreciated and the encouraged me to speak up what I liked what I did not like. So I did that audit and I filled in that things are not done according to NICE guidelines and yes he has made those changes and I presented that in front of all the staff in the surgery ..and they and they thought no its time for change .</p>	<p>Alluding to good team working:</p> <p>Team work not described in detail but he mentions a number of times the phrase:</p> <p>'Such a good team'</p>

4.2.2 Theme 4: Relationship with Practice staff

Précis:

The majority of interviewees reflected on the relationships between doctors and non-medical employed Practice staff (nurses and administration).

A good relationship with staff was characterised by trusting, supporting relationships, valuing of staff contributions to the work of the Practice and their inclusion in decision-making. A poor relationship did not foster staff contributions and was characterised by a lack of mutual understanding. Practices with a strained relationship between staff and doctors were also characterised by a more hierarchical relationship between doctors and employed staff.

A difficult relationship sometimes, although not invariably, affected trainees either because they were caught in the middle or because the atmosphere was tense. The nature of the relationship between partners and employed staff led trainees to reflect on the implications of the relationship with staff and their own stance regarding this issue.

Many interviewees reported good relationships between doctors and staff in their Practices (e.g. Arvind, Emily, Felicity, Oliver, Pamela). Such relationships were described as trusting relationships with staff knowing the doctors well. Some interviewees reported that their Practice encouraged informal social events with staff. Kay and Oliver reported that the value Practices attached to their staff was illustrated by the investment in staff development and their remuneration. Oliver (GPT) explains:

'I would be thinking of some of the partner meetings I've been in erm...I think they do care for their staff. I think they want to be fair to them and also generous where possible with the QOF bonus and they do pay a bonus to their staff.'

The value that Practices attached to staff was also illustrated in the extent to which staff were involved in meetings, included in discussions and had their concerns taken on board. A less hierarchical relationship between doctors and employed staff was portrayed in a more democratic nature of discussions of clinical cases and involvement

of the whole team in decision making. Such Practices were also described as more inclusive of trainees.

Kevin (GPT)

'From a clinical level, it seems to be very democratic. Everyone comes to coffee at a set time in the morning and there's dialogue about clinical problems or difficult patients or if someone has been offering a new service or a new initiative – it's all discussed quite openly with the staff. People are allowed to chip in what they feel about it'

However, not all Practices fostered good relationship with staff, with some being described as having more hierarchical and formal relationships between the doctors and Practice staff (Barbara, Becca, Eleanor, Gerard, Judith and Raj). For example Gerard (GPT) portrayed a more hierarchical relationship which discouraged staff from voicing their concerns:

'The disadvantage is that you are certainly....the staff below find it quite difficult to express when they've got issues with it because it is a system thing now...um...you do have the partners are the bosses which I guess they actually always are but in a particularly top down approach it seems like the staff find it difficult to actually say ' We really don't think we should be doing that' or 'We don't think that's appropriate' because they've got into that habit and that system where that's just the way it is and it is difficult to raise...'

A number of interviewees considered that a negative relationship between doctors and staff had some effect on them. For example both Gerard (GPT) and Judith (ECGP) felt awkward as they were caught up in the tensions between staff and partners, while Becca (GPT) explained how the tensions between one doctor and the administrative staff created a stressful atmosphere in the Practice. By contrast, although both Erica and Grant trained in Practices with hierarchical and often tense relationships between doctors and employed staff, neither claimed to have been affected. Possibly this was because both Practices were non-hierarchical and inclusive towards them as trainees.

The nature of the relationship between doctors and staff made trainees reflect on their own professional perspective on the matter, particularly with a view to future employment. For example, Gerard (GPT) thinking about his training Practice's attitude to staff, concluded that he preferred a more collaborative approach to staff management.

4.2.3 Theme 5: Relationships between the doctors in the Practice

Précis:

Interviewees talked about the relationship between partners in the Practice. They observed and made comments on the following aspects:

- Whether there were any tensions between partners.
- The degree of personal or social relationships between partners.
- Disagreement due to different approaches or styles.

Poor or tense relationships affected trainees in various ways. They reduced interaction within the team, resulting in fewer opportunities for informal learning, increased isolation and left a general feeling of being unhappy or uncomfortable at work. Poor relationships were also suggested to potentially affect patient's care. Nevertheless, poor or tense relationships did not always affect trainees adversely as in Practices where trainees felt included, seeing how difficult dynamics were negotiated was said to be useful for learning.

A number of interviewees described good relationships between partners in their Practices. These were manifested in mutual support and respect as well as in a personal friendship. Good relationships motivated trainees and were considered as a sign of a positive work environment.

A number of interviewees were aware of tensions between partners in their training Practices (for example Barbara, Eleanor and Raj). This was often manifested in a lack of social interaction and in poor personal relationships between partners. Strained relationships were suggested to originate from conflicting personalities or differences in approaches to patient management. For example Eleanor and Raj explain:

Eleanor (ECGP):

'Very strained the partners. It's not unusual for there to be low level disagreements at Practice meetings.. but there did seem to be a few kind of personality clashes in the way people liked to do things.'

Raj (ECGP):

'Christmas time was odd. At Christmas all the partners just ran off at Christmas and didn't say 'Have a nice Christmas,' which was not great. There was no Christmas spirit. They didn't have the decency for pleasantries for colleagues before they left.'

Strained relationships often resulted in reduced opportunities for informal social interaction that diminished opportunities for professional conversations. The importance of professional conversations in providing support for trainees was described in the theme 'participation in meeting' in the category 'inclusion'. It highlighted that participation in professional conversations, particularly during informal meetings, exposed trainees to different approaches to clinical management, increased confidence in dealing with uncertainties, reduced stress and raised awareness of non-clinical aspects of General Practice. Barbara, Eleanor and Raj, for example, all described how strained relationships meant that partners did not meet for coffee, with the result that they were unlikely to discuss cases and learn from one another.

Paul explains how having tensions in the Practice meant that doctors were less likely to discuss together the best way to manage patients:

'There was an article in the xxx magazine quite recently that said not getting on with your colleagues was bad for patient care and how, how true that is. You know, because when we should have been talking about how to best manage certain patients it was easier just to run run with it unilaterally than rather than knock on someone's door and discuss it so it's so so true that is.'

Several interviewees (for example Eleanor, Fatima and Raj) suggested that a tense atmosphere did not foster happiness at work and at times made trainees feel uncomfortable. However, tensions between partners did not always affect trainees, particularly in Practices where trainees felt included. For example, Geraldine (ECGP) explained that she was unaffected by the tensions between doctors because they worked well as a team on a day-to-day basis. She observed 'cross currents' during meetings:

'And I wasn't part of the cross current of that...I felt protected as a trainee as my trainer would discuss any issues or anything that was relevant to me.'

Good relationships between partners were also described by interviewees. Michelle (ECGP) portrayed harmonious relationships between the partners in her Practice. Alex (GPT) and Emily (GPT) described how good relationships were illustrated by a willingness to share work at a time of need and by the provision of mutual support. Personal and ‘family like’ relationships, mutual respect for difference and ‘getting on well’ were all identified as signs of good relationships.

Finally, a good relationship between partners motivated trainees and resulted in a positive working environment as illustrated in the interviews with Kay, Erica and Kevin. For example:

Kay (GPT):

‘I saw how well they all interacted and how much initiative they all took, and I just wanted to be part of that.’

4.2.4 Theme 6: Practice-patient relationships

Précis:

In describing their training Practices, interviewees commented on the balance in their training Practices between patients’ needs and income needs. They also reflected on the relationship between the Practice and their patients. These descriptions related to the extent to which Practices were oriented or embedded in the community, the extent to which Practices focused on meeting patients’ demands, the degree of commitment of the doctors in the Practice over and above what was felt was the norm and the emphasis or lack of emphasis on continuity of care. Practices that knew their patients well, were able to better support trainees in managing patients.

Interviewees commented on the relationship between the commitment to satisfy, on the one hand, the needs of patients and, on the other, the business requirements of the Practice. General Practices receive incentive payments in accordance with the QOF points they achieve. Trainees observed a tension between the commitment to patient care and the requirement to accumulate QOF points.

Such descriptions can be categorised under the following headings:

- a) Practices where patient care took priority over business needs (Alex, Fatima, Felicity, Grant, Kay and Samuel accounts). For example, Grant (ECGP):

'But certainly, I would say in xxxx, it's very much patient care. Almost probably to the detriment of the QOF points that they got, in that they really did focus on seeing people and what people needed.'

- b) Practices where patients' needs were 'balanced' with business needs (Arvind, Fatima, Andrew, Karen, Michelle, Pamela, and Samuel's first Practice). For example Michelle (ECGP):

'Primary concern was for patient care and providing good service to their patients, obviously wanting to meet costs and targets as well.'

- c) Practices with a strong business orientation (Barbara, Gerard, John). For example, Barbara (GPT):

'I get the feeling that this is a job rather than a vocation for a fair number of them and that business and money is very important, it is lucky in the sense it is not a deprived area so it is not great social need.'

In addition, the extent to which a Practice was involved in or perceived to be part of the local community was commented on, particularly by trainees from rural Practices (Judith, Felicity, John) but also in semi-urban Practices (Erica and Arvind). This differed from urban Practices where there is less focus on community involvement (e.g. Karen account).

The focus on meeting patients' demands occurred both in rural and urban Practices. For example Paul (ECGP) explains:

'So very, very patient-centred but urm there was a lot of focus on delivering on what patients wanted.. not necessarily what they needed.'

Trainees noted that commitment to patients often resulted in additional work for doctors. For example both Arvind (ECGP) and Andrew (GPT) describe the additional work, effort and long hours that partners in their Practice undertook, particularly as they

worked in deprived areas. Similarly both Samuel (GPT) and Oliver (GPT) explained how the partners' focus on addressing patients' needs and demands for appointments, resulted in a more chaotic running of the Practice. Michelle (ECGP) suggested that patient-centredness was also reflected in the style of consultation adopted by the partners in her Practice.

In contrast Karen (ECGP) describes a lesser degree of commitment:

'I think, well obviously they cared a great deal about the patients and they had a good admin staff behind them but they probably didn't do over and above what they needed to do and my trainer was very focused on ticking boxes for the contract.'

Other interviewees portrayed 'continuity of care' as a fundamental value of their training Practices (Felicity, Pamela, Erica). By contrast, John (ECGP) described one of his training Practices as characterised by a lack of 'continuity of care' due to a high turnover of doctors. 'Continuity of care' was considered by both Sange (ECGP) and Erica (ECGP) to be an efficient way of working and of providing better patient care. Practices that knew their patients well were able to support trainees in managing them as Fatima (ECGP) explains:

'And another thing was the partners knew a lot of the patients really well, so if you gave the name and said this person came to see me she was very angry about this thing and they'd be like 'oh she's always angry about everything, don't pay too much attention to it', you know so they knew their patient group really well as well so that was helpful. You know you could just give a patients name and you know one of them would know them and would be able to tell you 'ok, that person is always got low sodium' or something like that.'

4.2.5 Theme 7: Orientation of trainees to the ethos of the Practice

Interviewees discussed the ethos of the Practice ('hierarchy', 'progressiveness', 'team work', 'relationship with Practice staff', 'relationships between doctors' and 'Practice-patient relationship') and whether it was in agreement with their own values. Some strongly identified with the ethos of their training Practice. For example Andrew, Erica, Fatima Kay, Samuel, and Sarah, all identified with the approach of their training Practices to their patients. Andrew (GPT) describes it thus:

'I feel very much that patients are at the centre of the ethos here, so I'm really pleased about that, because I kind of share those values.'

Similarly Sabil (GPT) reflected that he wanted in future to work in a Practice characterised by the sort of good communication he experienced in his training Practice. Other interviewees did not relate to their training Practice ethos. For example, Barbara (GPT) did not share the business-orientated ethos of her Practice, while Paul's (ECGP) approach to patient care conflicted with the Practice's patient-centeredness ethos. Eleanor disliked her Practice's solitary nature and lack of team work and Gerard (GPT) could not relate to the hierarchical relationships between doctors and staff in his training Practice. Lack of congruence or the presence of conflict between trainee and Practice ethos often resulted in difficulties during training, described in more detail in Chapter 5.

4.2.6 Key issues of category 2- Practice ethos

- Hierarchical relationships between doctors and trainees had a negative effect on training. Practices characterised by such relationships were less adaptive to trainees' needs and provided fewer opportunities for them to be included and involved, thereby restricting their professional development.
- In contrast Practices characterised by less hierarchical relationships, fostered inclusive working relationships, with trainees feeling included, valued and able to play an active role and to contribute to decision-making.
- Practices characterised by less hierarchical relationship towards trainees, were also progressive and characterised by good 'team work. Such Practices had a culture of learning from mistakes and were more likely to take outside suggestions on board.
- Good teamwork was characterised by an equal sharing of workload and resulted in increased opportunities to support trainees through joint professional discussions. In contrast poor team work reduced such opportunities.

- Hierarchical or tense relationships between doctors and employed staff had a lesser effect on trainees.
- Poor relationships between doctors often, but not always, impacted on trainees by creating a tense atmosphere or by limiting opportunities for professional conversations and reducing consequent learning opportunities.
- Good relationships between doctors motivated trainees.
- Interviewees described their training Practices in terms of the relationship between Practice and patients and of the extent to which the Practice focused on patient and business needs. Practices that knew their patients well were able to support trainees in managing them.
- Interviewees commented on whether their Practice ethos was in agreement or in conflict with their own.

4.3. Category 3: *The importance of training within the Practice*

Summary of category 3 - the importance of training within the Practice

The ‘importance of training’ emerged as the third category describing the training Practice. The category relates to the degree of importance which interviewees felt was assigned to training within the Practice.

A training General Practice fulfils various functions. Its primary role is to provide patient care. However, it is also a business designed to create revenue for its partners and to meet its responsibilities towards employees. A training Practice also has responsibilities towards its trainees. The relationships between these three functions are often contentious as was reflected in the interviews. In particular, the need to provide patient care and the pressure to respond to patients’ demands was reported at times to impact on training. This category therefore describes these tensions and how they have been negotiated in different Practices.

The category covers a number of themes which reflect this category - ‘adaptation to trainee’s learning needs’, ‘perception of being used’, ‘caring and support for trainee’, ‘approachability and commitment’, ‘supervision’, ‘having more than one trainer’ and ‘organisation of work’.

Training Practices described as having a high priority for training enabled and trusted trainees to lead on identifying and addressing their own learning needs. They were inclusive and flexible in tailoring the training experience to the needs of individual trainees, allowing them a greater control over their work. By contrast, training Practices that were suggested to have a lower priority for training were less inclusive and flexible in accommodating trainees’ learning needs. The theme ‘inclusion’ therefore relates to the theme ‘adaptation to trainee’s learning needs’ (as illustrated in Chart 1).

Interviewees talked about whether they felt ‘taken advantage of’ to provide services and, if so, whether this had a negative effect on their training. Trainees who felt included were willing to take on additional responsibilities and unlikely to think that they were

being taken advantage of to satisfy workload demands. The theme 'perception of being used' therefore relates to the theme 'inclusion' (see Chart 1).

The care and support offered to trainees and the extent to which all the doctors were approachable were viewed as expressions of the importance of training within the Practice. Of special note were the pastoral care and support offered to trainees in dealing with significant clinical events or with complaints against them. Support and protection in dealing with such events were reported to be better in Practices where trainees felt included as part of the team. In Practices where trainees felt less included, they were not supported in dealing with such events, which reduced their confidence. The theme 'caring and support for the trainee' therefore relates to the theme 'inclusion'. In addition, Practices in which all doctors were described as 'approachable' tended to include trainees as part of the team. Therefore the theme 'inclusion' also relates to the theme 'approachability' (see Chart 1).

The level of supervision was also described by many interviewees. Adapting supervision to trainees' needs increased their sense of security and encouraged independent practice. Having more than one trainer in the Practice was also seen as a reflection of the importance of training within the Practice. Finally, a number of interviewees reflected on the organisation of work in their training Practices and how it impacted on them. Poor organisation resulted in an increased workload and in stress for doctors, including trainees, as well as limiting opportunities for informal meetings and personal study.

4.3.1 Theme 1: Adaptation to the trainee's learning needs

Précis:

Interviewees talked about the degree of support they received in identifying their learning needs and the extent to which their Practices exercised flexibility, allowing them to address unmet needs. These issues can be viewed as a reflection of the importance attached to training.

Some Practices were proactive in assisting trainees to explore their learning needs, encouraging them to address these in a variety of ways. The importance of training was also reflected in whether the time for teaching was protected.

Being flexible (in terms of rota, tutorials and length of appointments) and encouraging trainees to lead on identifying and addressing their learning needs were empowering. Practices of inclusive nature more readily adapted to trainees' learning needs.

Interviewees talked about the extent to which training Practices assisted them in exploring their training needs and paced the work to the level of their ability, particularly at the start of the year. For example, Arvind (ECGP) explained how his Practice used the compulsory attachment days during his hospital placements to familiarise him with the Practice and to help him identify and plan how to address his learning needs.

Practices also assisted trainees in addressing their learning needs by encouraging them to look after particular clinical cases, pacing appointments in line with their needs and abilities and allowing trainees to have control over reducing the length of their consultations.

Kevin (GPT) and Emily (GPT) described the adaptive approach followed by their training Practices which encouraged trainees to direct their own learning. The Practices exercised flexibility with rotas, private study time and tutorial content, allowing trainees to attend different clinics to address their learning needs.

Kevin (GPT) explains:

'It is very much a part of being sort of self directed, self identified and then sort of chosen the most appropriate, chose each work and given an opportunity to

choose what the tutorial topics were on... I think the Practice was quite flexible, was quite adaptive. Allowed me to have a say in the direction my education went in. So it was individualized.'

Both Michelle (ECGP) and Grant (ECGP) emphasised the flexible nature of and the variety of tutorial formats in their Practices. Samuel (GPT), on the other hand, described a set schedule in his first training Practice for duration of appointments and tutorial content that took little account of his own individual needs. This, he felt, reflected a low priority for training:

'I felt that my training was not the priority because there was so much reluctance to adapt to my needs as a trainee or to adapt or to, to sort of adjust what workload I had to do depending on my, you know, other sort of demands of my training; so I felt that perhaps not just as a trainee that I was undervalued but that the importance of my training was undervalued as well and that the most important thing was the efficient running of the Practice'

Section 4.2.1 narrated that Practices not inclusive of trainees were also hierarchical, not progressive and did not readily adapt to trainees' needs. Table 7 (p. 141-147) provides further evidence that Practices not inclusive of trainees did not readily adapt work and experience to learning needs. As against that, Practices inclusive of trainees were more flexible with rotas and tutorials. They enabled and encouraged trainees to lead on addressing their own learning needs. The themes 'inclusion' and 'adaptation to the trainee's learning needs' are therefore interrelated as illustrated in Chart1. Allowing trainees to be in control was empowering and encouraged them to be self-directed.

Samuel (GPT) talked about his experience in his second training Practice.

'In this Practice I feel the learning has been much more sort of individual and flexible, so, um, the pacing of appointment times and tutorials and what was covered in these tutorials, um, what clinics I sat in on and so on, were all very individual and very much, ah, I was very much encouraged to sort of lead my own learning.'

Finally, allowing appropriate time for tutorials and protecting tutorial time were also identified as illustrations of the importance of training by a number of interviewees (Alex, Kevin, Michelle).

4.3.2 Theme 2: Perception of ‘being used’

Précis:

The tension between service provision and training was illustrated in many interviews. Interviewees often talked about whether they felt their training Practices viewed the trainee as ‘a service provider’ or a person who came to train. If the former, it was more difficult for trainees to adjust rota and workload, attend specialist clinics or meetings, have adequate tutorial time or even take study leave.

When trainees did not feel included in the Practice, they were more likely to perceive that they were being taken advantage of.

Not taking advantage of trainees to satisfy workload requirements was seen by interviewees as a reflection of the importance attached to training. Paul (ECGP), Becca (GPT) and Sabil (GPT) for example, felt that their Practices viewed them as trainees rather than ‘service providers’. Becca (GPT) explains:

‘Most people that I have talked to they just (other trainees) were viewed (by their Practices) as the people that will do the work, you know they were there to do all the work in the Practice. But this Practice, the emphasis was on registrars being trained... So if there was anything that needed covering, they would get a locum.... they really emphasised that you’re a registrar, you’re a trainee, you’re not to cover our shortages or things like that.’

Other interviewees felt that their Practices relied heavily on them to provide services to patients, with a negative impact on their training. For example Eleanor described not being allowed study leave to attend courses, while for Judith it was difficult to attend women’s health or other specialised clinics available in her Practice.

Table 7 (p. 141-147) illustrates that Interviewees who felt their Practices relied heavily on them to provide service to patients, also reported feeling less included as part of the team in their training Practices. On the other hand, those who felt included in their training Practices and valued as members of the Practice team, were less likely to perceive their training Practices to take advantage of them. They felt their contribution to the work of the Practice was acknowledged and appreciated and were more likely to feel

that their work was part of the Practice team's effort. The themes 'inclusion' and 'perception of being used' are therefore interrelated as illustrated in Chart 1.

4.3.3 Theme 3: Caring and support for the trainee

Précis:

Interviewees talked about the feeling of being 'cared for' or 'supported' by the Practice. Again, caring and support can be seen as a reflection of the importance of training within the Practice. Two important aspects emerged, namely, 'being cared for' on a personal level and 'being cared for' on a professional level. Being 'cared for' and 'supported' on a personal level was reflected in the pastoral support provided to trainees when dealing with difficult life circumstances. Being 'cared for' on a professional basis related to the support offered to trainees in dealing with clinical work, significant clinical events or difficult clinical encounters.

Professional support or lack of it was illustrated in the way the Practice responded to complaints against the trainee or other significant or difficult events. Where trainees felt included and 'part of the team', they reported being support and protected during such 'adverse events'. In Practices where trainees felt less included, they reported lack of support which made them less confident in dealing with such situations in future or doubting their abilities as GPs.

Interviewees talked about being 'cared for' on a personal basis and being 'supported' through difficult life circumstances (for example failing exam, early birth of a child, illness or death in the family etc). Forming positive relationships within their training Practice contributed to a feeling of personal and professional support and occurred where trainees felt integrated into the team. Sabil, Becca, Oliver, Sange and Kay all described how their training Practices supported them through difficult personal situations and all felt included and integrated into their Practice teams. Sange (ECGP) described the support he received when his son was born early:

'And they were really helpful, they didn't ask me to come after she was born, they said 'Your paternity leave starts straight away, you don't need to come for

next two weeks, provided you want to see us, you can come and see us'. So they were really helpful'....everybody individually, gave me so many gifts when my little one was born which was overwhelming and there was not even a single person who did not offer me a card at least.'

Support and protection on a professional basis centred around two main areas - support with clinical work and support in dealing with errors and significant events. Support and protection were reported by trainees who felt included but not by those who felt less included. The relationship between the themes 'inclusion' and 'caring and support for trainee' is illustrated in Table 7 (p.141-147).

Professional support was particularly noticeable in the response to difficult clinical encounters such as near misses or significant events. Practices where trainees felt included and part of the team were said to provide good support in dealing with such events. Sarah (ECGP), Sabil (ECGP) and Emily (GPT), who felt included, reported a supportive approach by their Practices in response to such situations. Sarah (ECGP) described her involvement in a significant event relating to child protection and the way in which the Practice protected her from the family involved and supported her emotionally:

'But there was one situation quite early on with a child who had gone up to (name of hospital), and it was quite a distressing situation, erm, and very quickly things escalated out of all proportion. And, erm, the family were very upset with things, and very quickly the trainers took it on and spoke to the family and, you know, it was removed necessarily from me.'

'You know, they were very helpful asking how I had felt about the situation and things like that, so, erm, it wasn't ever a very negative (thing) and then they encouraged me to do a significant event about it, which the whole Practice has learned from, and actually we have changed some of the practices as a result of what's actually happened'

By contrast, Barbara (GPT), who did not feel included in her Practice, spoke of a lack of support in dealing with a patient's complaint which was forwarded to all partners and discussed in a Practice meeting without her prior knowledge. She was left to deal with the complaint herself with no support from the Practice or trainer and explained how this reduced her confidence in dealing with similar situations in future.

‘

Table 7 (p.141-147) provides further examples of support or lack thereof in dealing with significant events or difficult situations in Practices that were described to be inclusive and less inclusive of trainees (see Samuel, Eleanor versus Emily and Sabil).

‘Caring’ for the trainee on a professional level was also reflected in career advice offered to trainees. It often extended beyond the training period, with the Practice keeping in touch and supporting trainees in the early years of their career.

4.3.4 Theme 4: Approachability – Approachability and commitment to training by the whole Practice.

Précis:

In describing their Practices, many interviewees talked about ‘approachability’, described as the sense of ease and comfort with which one could approach other doctors or Practice staff and ask for advice. Approachability can be seen as a reflection of the importance of training within the hierarchy of Practice functions. So for example, if training is important, the ethos of training is embraced by all, with non-training partners and Practice staff all being approachable and amenable to trainees. Commitment to and enthusiasm for training are therefore a reflection of its importance.

‘Approachability’, particularly of non-training partners, was highly valued by trainees. Doctors being ‘unapproachable’ reduced opportunities for support. Practices described as inclusive were also described as approachable. Commitment and enthusiasm towards training was also illustrated in the opportunities provided for trainees to seek advice and to have tutorials with partners with specialist interests.

The approachability of doctors in the Practice was commented on by most interviewees. Approachability, of doctors who were not trainers, was important to trainees and was particularly valued in Practices where the main trainer was working part time. It enabled trainees to have a ‘safety net’ when the main trainer was not available. It was important for trainees to feel that they were not ‘disturbing’ other doctors, that delays associated with seeking advice were acceptable and that asking was a legitimate part of training, not

a pitfall. This was reflected in comments from a number of interviewees. For example Alex (GPT) explains:

'They were happy to take questions and made it obvious that they didn't think you were silly for asking questions and kind of encourage. They were basically clear that I was welcome to ask questions at any time.'

Other interviewees described the doctors in their Practice to be less approachable (Judith, Raj, Eleanor and John-second Practice). For example Raj (ECGP):

'A couple of individuals were not most receptive and did not want to be bothered by a trainee often. ..Some doctors had a shorted fuse though and may even get angry.'

Eleanor explains how the unapproachable nature of the doctors in her Practice meant that her questioning was interpreted as poor performance rather than a need for reassurance:

'And that was the difficult part, finding someone or feeling welcome to share your doubts. I often felt quite singled out maybe for 'why don't you know this?' when perhaps I was trying to be super honest and saying 'well, I don't know this, that's why I'm asking'.'

Not welcoming trainees and being unapproachable can therefore result in a feeling of exclusion from the Practice as John (ECGP) explains.

'They thought they didn't have anything in common with me, I was a trainee of (name of trainer) and that's yeah...I was seen as a registrar...in the Practice, yeah...but not really as part of the Practice.'

Practices that were described to be inclusive of trainees were also described as approachable. Conversely Practices that were described to be less inclusive of trainees were described as less approachable (see Table 7 p.141-147).

Commitment to training by the Practice as a whole was also illustrated in the opportunities offered to trainees to seek advice and to have tutorials with non-training partners in the Practice. For example, both Paul (ECGP) and Sabil (ECGP) talked about having tutorials with doctors in the Practice who had special interests (e.g. orthopaedics, cardiology). This was not the case for Karen (ECGP) as none of the partners in her

training Practice were involved in or keen on training. This can be seen to reflect a low priority for training.

'Historically they'd never been involved in training and they had a lot of commitments, I think, out with their working lives and so were very reluctant to get involved with training. And I think also probably felt, certainly one of them felt, that she was maybe a bit out of touch with what would be needed to give a tutorial or these kind of things.'

Being made to feel comfortable and supported by non-medical staff was also commented on (Alex, Kay, Geraldine). Commitment and enthusiasm for training from everyone in the Practice team can be seen to reflect its importance to the Practice.

Table 7 provide quotes from some of the cases to illustrate the links between the themes ‘inclusion’, ‘adaptation to the trainee learning needs’, ‘perception of being used’, ‘caring and support’ and ‘approachability’. It illustrates that Practices portrayed as inclusive of trainee, were also described to more readily adapt to trainees’ learning needs, to provide better care and support and to be approachable to trainees. Is such Practices trainees did not feel they were taken advantage of (see Geraldine, Kay, Pamela, Sabil and Emily). The converse also applies (see Eleanor, Gerard, Judith, Samuel and John).

Table 7: Themes relating to the theme ‘inclusion’

Interviewee	Perception of inclusion	Adaptation to trainee’s learning needs	Perception of being used	Caring and support	Approachability
Eleanor	<p>Not feeling included: <i>I think just generally, this solitary environment that was thrust upon everybody, I mean, everybody worked like this. You were really encouraged to get used to the fact that you will be working on your own.</i></p> <p><i>I suspect now that the Practice manager did meet with the administrative staff at other opportunities, but we weren’t involved in that, I was never invited.</i></p>	<p>No study leave to enable trainee to address learning needs: <i>During the year tended to go on a few courses and at no point was I ever given any study leave. I tried to as well take a couple of days, I can’t remember, a lot of the partners were on holidays so I was told I couldn’t have those days as there wasn’t enough doctors.</i></p>	<p>Perception of being used: <i>I often felt that I was overloaded with work as a registrar and I think that a lot of things were, not necessarily palmed off on me, but perhaps should have been dealt with by others. I’ve never had that happen to me in any of my long term jobs since.</i></p>	<p>Lack of support with workload: <i>I was left without a partner on site.</i> <i>I have a very, very clear recollection of me and the salary doctor being the only people in the Practice one Friday afternoon and trying to juggle a couple of things. I didn’t have anything ‘majorly’ complicated to deal with that afternoon, but it would have been quite nice for, say my trainer to stay with me, or one of the partners to stay, to say “are you all right?”.</i></p>	<p>Difficult to approach: <i>I found the Practice, I found it quite hard sometimes to feel 100% welcome to ask for advice. I was quite, I’m not a ‘majorly’ outgoing person, but I’m not seriously shy either. I did sometimes feel a little bit intimidated, particularly if people felt they were being interrupted, which was a little bit tricky at times. In fact a couple of them would be quite genuinely unfriendly at times.</i></p>

Interviewee	Perception of inclusion	Adaptation to trainee's learning needs	Perception of being used	Caring and support	Approachability
Gerard	Not feeling included: <i>I mean certainly as a trainee you don't tend to get asked your opinion that much in these sorts of meetings even with clinical...you know we're free to pitch in and offer thoughts but not really...we don't really get encouraged – nobody turns to us and says 'And what do you think.</i>	No particular examples given	Perception of being used: <i>And I think there is, there's a tendency for the Practice to give you things under the guise of it being educational for you, and actually it's just that they want someone to do it. Um, yeah, it's quite a good cover.</i>	Lack of personal support: <i>But equally, that doesn't apply just to me, that's applied to other people that have had problems at home in that Practice as well. They're initially supportive and then seem to try and push stuff back on, er, without checking that you're...that, that's where you are, that you're ready and things.</i> (talking about duty doctor): <i>you are just gonna be left to do it on your own, um, it just feels like there maybe was a better way to approach it sometimes.</i>	Approachability not directly described :
Judith	Not feeling included: <i>I think sometimes you just don't feel that you're in that position because they've had trainees for years they are quite a notorious Practice for being a training Practice, they know what they're doing.</i>	No identification of learning needs and plan for addressing them prior to starting the St3 year: <i>But didn't really get any exposure until I hit ST3, erm, quite...I hit the ground in ST3 and had a very steep learning curve at that point.</i> Tutorials did not address trainee's specific learning needs: <i>Sometimes felt the tutorial time wasn't enough..</i>	Perception of being used: <i>You weren't an extra pair of hands they needed you there, they would be stuffed without a registrar, they did really rely on you.</i>	Lack of support : <i>Yes, I do remember being quite annoyed thinking, oh this is ridiculous all my friends are having observers there, they're having, you know, their lists, their patients reviewed all the time, and very much hand holding: I was told, 'Uh-uh get on with it!'. so I did sometimes feel a bit flung in at the deep end.</i>	Implicitly discouraging trainee to ask for help: <i>Most of the time when I tapped the door, fine, they would come through, not a problem, but you could tell it was just, ..erm, so there was always this feeling of time is, you know, short, got to get a move on here.</i> <i>Erm, you certainly</i>

Interviewee	Perception of inclusion	Adaptation to trainee's learning needs	Perception of being used	Caring and support	Approachability
Judith		<p><i>I would have a list of patients I needed to ask particular questions about. there wasn't a huge amount of time for that.</i></p> <p>Difficulty to attend speciality clinics:</p> <p><i>Yes, I did a couple of times (attended specialised clinics), I think as the year rolled on, because you've got your own booked surgeries; you, you can't always get to these things, ..because it was very much you just need to be doing surgeries, you just need to be seeing people, blah , Blah , Blah'</i></p>			<p><i>learned whose door to chap on for what. You know, some people were maybe slightly more receptive than others or more helpful than others.</i></p>
Samuel	<p>Not feeling included:</p> <p><i>I mean I felt in the, in my previous Practice, um, I was sometimes invited to the management meeting, but sometimes I was asked, quite regularly asked, to leave, um, so that decisions could be made, you know in my absence and without my hearing about them, um, which made me not really feel part of the team there.</i></p>	<p>Resistance to adaptation of work to trainee's needs:</p> <p><i>I felt that my training was not the priority because there was so much reluctance to adapt to my needs as a trainee or to, to sort of adjust what workload I had to do depending on my, you know, other sort of demands of my training.</i></p> <p>Tutorials not addressing trainee's specific learning needs</p> <p><i>Sometimes the topic of tutorial</i></p>	<p>Perception of being used:</p> <p><i>The, the focus on, um, money meant that, even quite early in training I felt that some of the work I was doing was not educationally beneficial and was simply part of the Practice's way of making it financially more efficient.</i></p>	<p>Lack of support for trainee in dealing with significant event:</p> <p><i>I think that made me feel very uncomfortable that, you know, there was a clinical risk that I was trying to make a difference to and that wasn't welcome.</i></p>	Not described

Interviewee	Perception of inclusion	Adaptation to trainee's learning needs	Perception of being used	Caring and support	Approachability
		<i>was quite fixed as well, ..., I didn't feel that things were particularly flexible to my needs as a trainee, because you know it was well-established and this is the way things ran.</i>			
John	<i>Not feeling included:</i> <i>I was seen as a registrar...in the Practice, yeah...but not really as part of the Practice, which I think is the weakness of the large Practice and I was seen more like a...like a....helping hand rather than a trainee...</i>	<i>Less adaptive to needs: Describing a situation where the Practice did not cancel patients to allow him time to prepare for exam:</i> <i>Mary (the trainer in the other training Practice) felt that as I was going for my CSA it would be better for me to be with her at xxx.. but David (the trainer in non inclusive training Practice) felt that it was not fair on the receptionist staff (to cancel all the patients) at the last moment and there were a few words, yeah...[laughs] I was caught in the middle.</i>	<i>Perception of being used:</i> <i>There was always the temptation...by the, the receptions were always tempted to add on a few more patients and at the end of the day there were a few instances I had seen more patients then the regular GPs.</i>	<i>Does not describe support from the Practice.</i> <i>As john trained in two Practices simultaneously , he described receiving personal and professional support from his other Practice but not form this Practice.</i>	<i>Doctors Not approachable:</i> <i>I think the difficulties was with um...relationships with other doctors, I mean, I would say that I many times felt that they were quite unfriendly, yeah...because I mean some of them would not say 'Hi'.</i>
Geraldine	<i>Included, feeling equal:</i> <i>Towards the end the doctors were asking about what the latest advice was on various conditions. So I wasn't always just at the bottom of the pile.</i>	<i>Having control over reducing the length of her consultations:</i> <i>It was in consultation between me and the trainer. The ball was in my court. From November / December I had a chat and decided on doing 10 or 15 minutes sessions.</i>	<i>Not taken advantage of - Perception of working as part o the team:</i> <i>I felt like I helped out by taking on more patients. They greatly appreciated that. My being there gave them more admin time. So I felt I had a positive contribution. They fed</i>	<i>Supportive</i> <i>I felt protected as a trainee as my trainer would discuss any issues or anything that was relevant to me.</i> <i>They really wanted to make it work and support me.</i>	<i>Easily accessible</i> <i>There was an immediate "bubble" system where you could instantly message other doctors and I felt comfortable asking for help when I needed it or asking for advice when I</i>

Interviewee	Perception of inclusion	Adaptation to trainee's learning needs	Perception of being used	Caring and support	Approachability
Geraldine			<p><i>back that this was helping them. They weren't expecting me to be able to lighten the load.</i></p> <p><i>When a doctor was off sick the other got a bit more stressed but it didn't affect me to that extent. There was always that buffer there.</i></p>		<p><i>wasn't sure about a patient of what form to use. I didn't feel like I was pestering them because that was the way they operated and everyone was ready to respond to it.</i></p>
Kay	<p>Included , feeling part of <i>I think the most important thing was the team work and being made to feel like part of the team and so that made me want to better myself so that I would be kind of a useful part of that team.</i></p>	<p>Having control over reducing the length of her consultations: <i>I suppose that is quite empowering from your learning point of view that, feeling I wasn't under pressure.. being just supported to go as you wish is really helpful.</i></p> <p>Tailoring clinical cases to address trainees' learning needs <i>For example,, there was a patient who no-one had met who was a palliative care patient and my trainer thought for my training that would be really good to see a palliative care patient, a new patient and it was really good, he died and I followed him through with the palliative process and that was really helpful.</i></p>	<p>Not taken advantage of- Perception of working as part o the team <i>I don't feel ever that I have been put upon or asked to do anything extra or dumped on because I am the reg, which I think can happen to other people, but it hasn't happened and I think just being part of the team is how they have done that.</i></p>	<p>Support with difficult patients: <i>So I mentioned this (threatening) patient during this time when we can discuss problem patients so that the other GPs were aware of him and the Practice manager was there, she then told the receptionist staff about the problems I'd been having with him, and that worked really well, because when he next came to see me the receptionist phoned through that he had turned up in open surgery, ..the Practice manager actually stood outside my door whilst I consulted with him to make sure I was safe.</i></p> <p><i>I felt all the time that everybody was behind me to help me do well so everybody was very supportive.</i></p>	<p>Accessible and approachable: <i>I know that for the first few weeks that kind of went so they would have a full surgery with a few gaps in case I needed them, but there would still be someone allocated, just in case, which was really nice... I just knew that I had someone there, I wouldn't have to interrupt, they would just be there.</i></p>

Interviewee	Perception of inclusion	Adaptation to trainee's learning needs	Perception of being used	Caring and support	Approachability
Pamela	<p>Included , feeling part of Any everybody's opinion is as important as anybody else's..</p> <p>You know like Practice meetings, I was encouraged to be a part of the Practice meetings ..whereas I would go to these meetings and speak quite freely.</p>	<p>Work adapted to leaning needs- encouraged to follow patients:</p> <p>I was encouraged by one of the partners to feel free to bring things back even if things had resolved but for my own learning to see that things had resolved.</p>	<p>Not taken advantage of- Perception of working as part o the team</p> <p>Because my door was always open and I was always happy to do it, I wasn't very good at saying no (about extra work)</p>	<p>Professional and personal support But if you had concerns, professional concerns, there were always dealt with kind of appropriately, they weren't kind of your concerns weren't belittled, so I think that was important.</p> <p>My Granny took very unwell and died whilst I was in that job and I was the only person in Scotland, I was out and I had to phone my trainer and say look I've got 2 booked surgeries this afternoon, I don't know what to do, I can't think straight, what do I do. And he dealt with it so wonderfully well.</p>	<p>All approachable I always felt very welcomed to speak to any of the partners, about kind of other clinical situations, or knock on their doors and everyone was very accommodating.</p>
Sabil	<p>Included , feeling part of I was part of the team and not feel like a trainee.</p>	<p>Practice responded to trainee request for easier access to supervisors: I said I don't want to wait that long and they were very nice they said Sabil what do you think should be done about this? we understand everybody is busy in the Practice at the end of the day your training is important as well and you should not feel you are let</p>	<p>Not taken advantage of- Perception of working as part of the team I was asked initially if I would be happy to look after the nursing home patients on a regular basis and I agreed and that helped me and I helped the Practice they appreciated my input.</p>	<p>Professional support in dealing with significant events:: Talking about partners reaction to a significant event: Very supportive not only the trainer you know all the partners in the Practice I have to say very supportive – it can happen – it can happen yeh.</p> <p>Adjusting workload before exam: And the Practice manager came</p>	<p>All partners approachable: So they were all part time everybody was there for two days a week I was there five days week so at any particular day I could find a trainer there one of these partners so if I had any problem I would go to them to, him</p>

Interviewee	Perception of inclusion	Adaptation to trainee's learning needs	Perception of being used	Caring and support	Approachability
Sabil		<p><i>down so we came up with an idea - I used to take that strap under the door</i></p> <p><i>'I never felt that my concerns were ignored at any stage so that was very good yes'.</i></p>		<p><i>to me and said look Sabil 10 minutes for full day is going to be very tiring for you so how you do feel about see two patients 10 minutes and then have 10 minute break and then two patients ten minutes and then ten minute break.</i></p> <p>Personal support: <i>Staying away from family very hard yeah but again the Practice people never let me feel that way They were always there for me they were so flexible so so flexible you know.</i></p>	<i>and speak and discuss my problem.</i>
Emily	<p>Inclusive <i>There wasn't anybody else who wasn't a partner apart from me. So, for them to have had separate meetings, and talked about it when I wasn't there, would have excluded me quite a lot. So, they didn't ever do that. So, everything, pretty much everything was just talked about at coffee, or, um, at their Practice meeting.</i></p>	<p>Allowing trainee to adapt the work to meet her learning needs: <i>They were very flexible, so things like, I did quite a lot of family planning, and, um, so I could really...I organised the rota as much as I wished, which was quite good. I didn't...they were quite careful not to treat me as a locum.</i></p>	<p>Not taken advantage of <i>They were quite careful not to treat me as a locum.</i></p>	<p>Supportive <i>They were very good and very supportive, and it was friendly, and, um, you know, the ladies at reception were friendly, and the administrative staff would do things for you '</i></p> <p>Talking about her misdiagnosing a patient: <i>I think whenever anything sort of did go wrong, people are very supportive, um, and they were...and in fact they were quite protective, I would have said.</i></p>	<p>Approachable <i>Everyone was very helpful. Um, it was really friendly. Um, they were always keen to give you advice.</i></p>

4.3.5 Theme 5: Supervision

Précis:

The level of supervision of clinical work was an issue raised by all interviewees. Adapting supervision and support to the needs of trainees was important and can be seen as a reflection of the importance of training to the Practice. When supervision was appropriate to the needs of trainees it fostered security and independent practice. When level of supervision was not adapted to the needs of GP, it left trainees doubting their ability to cope with General Practice work.

Explicit supervision arrangements-knowing that support is always available and feeling comfortable to seeking it, enhanced a feeling of security and encouraged independent Practice. This was reflected in many interviews. For example Geraldine (ECGP) explains:

'I was happy to be able to do my own surgeries. Also knowing I had backup was useful as a safety net. So I felt quite comfortable while being independent.'

Having an appropriate balance between support and supervision while practicing independently, was deemed important. Adapting supervision to the needs of individual trainees was also identified as important.

A comparison between the cases of Arvind and Judith provides a useful illustration of the importance of adapting support to the needs of trainees.

Arvind (ECGP)

Arvind, an immigrant doctor who previously trained as a surgeon, was unfamiliar with primary care in Scotland. He outlines his difficulties and how the Practice tailored induction and support to address his learning needs:

'I basically had to start from scratch, being from surgery, my knowledge of general Practice was very limited, kind of starting from scratch, how the whole of general Practice works, how the primary care trust works, the whole understanding of it.'

The Practice response was to assist him in identifying his learning needs and tailoring support accordingly. He explains that the Practice tailored his induction period to his needs:

'They were very kind of patient and understanding, giving me a good idea of how things work, what is expected, other support things available in the community.'

'I had one of my talks with the district nurse: 'what kind of things they do?'. Once I sat down with the Practice nurse just to get an idea of the kind of aspects of where to point, where the physiotherapy is, what other things we have in the community.'

In addition, the Practice paced his workload to allow him to build up his confidence:

'Initially they did give me plenty of time to start with, start work at 20 minute or 30 minute appointment. 'Take your time getting to know the computer system, take your time to know the patients.' And as you feel confident, kind of cut it down but that way it was really good.'

This was very different from Judith whose Practice was less responsive to her needs:

Judith (ECGP):

Judith found the initial few months in general Practice stressful. She was lacking in confidence which added to her stress. She felt the Practice did not provide her with adequate supervision and support which could have assisted her during this difficult time. As the Practice did not tailor the level of support to her needs, this resulted in Judith feeling less confident and consequently doubting her career choice:

'I suppose the GPs in the surgery were a wee bit older as well, and they had quite high expectations of the registrar and very much that you just would cope, so I did sometimes feel a bit flung in at the deep end, certainly compared to when I spoke to some of my peers who were maybe being supervised a lot more, I did feel slightly flung in at the deep end, and definitely the first few months I felt really stressed.'

'I think to begin with, the lack of support to begin with, and that you didn't have your surgeries checked,...and I didn't ever have anybody sitting in while I consulted.'

She explains how this contributed to her lack of confidence:

'Everything, time because you're under pressure because you've got loads of other stuff that you know is waiting, and people who are waiting to be called or seen, erm,

lack of experience and lack of knowledge and feeling unconfident was definitely an issue to begin with; I felt hugely unconfident to begin with.'

'So I think there's just, I think in my case they kind of maybe overestimated how capable I would have been, and actually I needed a lot more help at the beginning, which wasn't added at the time.'

This resulted in her doubting her career choice:

'Definitely the first few months I found incredibly stressful. Partly, part of me going, I'm not sure I can do this, I'm not sure this is what I want in the future. You know, you start questioning your actual career decisions at some point, but something just kept me in there, I don't know what it was.'

'But you kind of just felt, felt my way into it really, but I don't think it was ideal at all, erm, I'm sure there's a better way of doing it.'

4.3.6 Theme 6: Having more than one trainer

Précis:

This was a small theme which was mentioned by a number of interviewees. Having access to more than one trainer was described as beneficial.

Having access to more than one trainer in the Practice provided opportunities for trainees to see different approaches to and styles in the management of patients. Kevin (GPT), for example, reported that he benefited from having trainers with different styles, one described as a 'pragmatist', the other as a 'theorist'. Similarly John described one of his trainers to focus on consultation skills while the other emphasised the importance of evidence based Practice. Andrew (GPT) pointed to the advantage of having his workplace-based assessments carried out by different trainers:

'It's been useful as well because I've had both trainers doing assessments with me at times, ...they admitted it, very different styles and so it means that I get a very fresh or different way of approaching...um...the way I've managed a patient or something like that. So I think, the fact that there are two trainers is good in itself.'

Having more than one trainer in the Practice meant that support was still available when one was absent. It was particularly useful when a trainee had difficulties with the main trainer as Raj (ECGP) explains:

'He (the second trainer) was nicer in that respect and was a lot easier to speak to and more open and honest. He was aware of being constrained in his style of work, even in the tutorials as someone was looking over his shoulder. A lot of what I was feeling he felt too. He was a lot more relaxed and a lot easier to talk to.'

4.3.7 Theme 7: Organisation of work and its impact on training

Précis:

A number of interviewees commented on the way the work was organised in their Practices and how it impacted on their experience during training.

Work was deemed not well organised when doctors were undertaking tasks which could be done by others (nursing or administrative staff). Poor organisation of work resulted in increased workload and stress for all doctors, including trainees, and reduced opportunities for informal meetings and personal learning time. This theme was relatively minor and merits further exploration by another study. Nevertheless, it suggests that the way work is organised does affect doctors and may even impact on patient care.

A number of interviewees described the way in which work was organised in their training Practices, pointing out the impact of inefficiencies on the work of doctors, including trainees. Fatima (ECGP) explained that administrative tasks such as typing letters or 'chasing up' patients were completed by doctors, adding to their already heavy workload. Oliver (GPT) described a lack of clear instructions to reception staff as to the type of patients a duty doctor was expected to see, increasing the stress on the duty doctor while John (ECGP) suggested that a lack of nursing staff in one of his training Practices resulted in inefficient chronic disease management:

'We didn't have enough nurse practitioners or Practice nurse's times to sort of help up with the job and I think the nurses do the QOF jobs sometimes better than GPs...It has become something like a vicious cycle because the GPs are always fire fighting and there is little time for...like going on to do proper chronic disease um...management.'

Poor work organisation, with a consequent increase in workload, was seen to impact on trainees by increasing stress and reducing opportunities for informal meetings and personal learning. Andrew (GPT) explains:

'If we used the reception staff more or we used the other members of the team more effectively, that that would reduce the doctors workload and make life a little bit more pleasant, especially for the trainee, who has not got the experience that the partners have and maybe there would be slightly more time during the day for things like that (getting together at coffee break). It would be great probably for everyone.'

Work was deemed well organised when administrative tasks were delegated to non-doctors and when appointments during surgeries were structured in a way that enabled trainees to cope with administrative tasks, resulting in less stress and better decision-making. For example Becca (GPT) explained how the effective organisation of work in her second training Practice reduced her stress level and improved her decision-making. It also made the Practice environment more relaxed and less stressful for everyone:

'So virtually all the administrative stuff that can be done by administrative staff is done by administrative staff ... the doctors concentrate on the clinical thing.'

'They (the doctors) just stop for data inputs which is just one slot for me to catch up. And it's a very useful thing, it makes a huge difference, because if you are working and you are running late, you get tense and because you are that tense, your concentration gets worse. ...I mean you catch up and then you feel more calm ready for the next patient. ...And when I say more relaxed they are not doing less work they are actually doing more work (than her first Practice).'

4.3.8 Key issues of category 3- the importance of training within the Practice

- Practices that gave a high priority to training were described as inclusive of trainees. They readily adapted trainees' work in line with their learning needs, allowing them to lead on addressing them.
- When trainees felt included in their training Practices, they readily took on additional responsibilities. When they did not feel included, they were likely to think that they were being used.
- Personal and professional support for trainees reflected the importance of training to the Practice.
- In Practices where trainees felt included and part of the team, there was professional and emotional support in dealing with personal and professional difficulties. Practices where trainees felt less included were less supportive of trainees, which reduced confidence and increased self-doubt.
- A commitment to and enthusiasm for training by all, were viewed as a reflection of its importance, manifested particularly in the approachability of non- training partners.
- When supervision was adapted to their needs this reflected a high priority for training in the Practice
- Having access to more than one trainer was a further reflection of the importance of training and was perceived to be educationally beneficial for trainees.
- Poor work organisation increased workload and associated stress for all doctors. It was thought to impact on certain learning opportunities (such as informal meetings, time for personal learning).

Chapter 5: Findings- Construct 2-‘The GP trainer’

Introduction:

The second construct which emerged from the interviewees’ descriptions of their training Practices was ‘the GP trainer’. There were 61 initial codes in relation to this construct (see Appendix 7). Further analysis (second stage analysis described in Chapter 3, p.88) yielded 11 themes which were grouped under three categories. Categories and related themes are described in the Table 8 below.

Table 8: Construct 2-The GP trainer: categories and related themes.

Category	Themes
Personal qualities of trainer	The trainer as a doctor
	Approachability of trainer
	Understanding of trainee’s learning needs -adaptation of teaching and feedback to needs and adaptation to trainee’s learning style and professional approach.
	Experience as a GP and trainer
	Commitment to and enthusiasm for teaching and knowledge of the assessment
Trainer-trainee relationship	Personal relationship with the trainee
	Honesty and trust in trainer-trainee relationships
	Conflicts
The teaching	Effective teaching and feedback
	Less effective teaching and feedback
	Challenge

Overview of Construct 2- The GP trainer

When describing their training Practice, 'the GP trainer' emerged as a second construct containing 3 main categories: 'personal qualities of the trainer', 'trainer-trainee relationship' and the 'teaching'.

Personal qualities of the trainer were derived from the trainer's qualities as a doctor, which encompassed their professional attitudes and their relationships with patients, their approachability to trainees, their understanding of trainees' learning needs and their adaptation to and acceptance of trainees' learning styles and professional values. Commitment to and enthusiasm for training were also important, with length and level of experience as a GP and trainer being less so. Acceptance of trainees' professional values allowed the trainee to develop their own professional style and approach.

Interviewees also described their relationship with their trainers. Positive personal relationships with trainers left them feeling well supported. In addition, trusting and honest relationships promoted learning opportunities. It is suggested that the key to a positive relationship was the ability of the trainer to accept or adapt to the trainee's personal ethos or style, allowing them to develop their own professional approach.

When trainees experienced difficulties in their training, this normally came about due to trainee's personal ethos conflicting with Practice ethos, trainer ethos or both. Difficulties were characterised by a poor relationship between a trainee and a trainer, with the trainer often being perceived as insensitive or lacking an understanding of the trainee's needs. This often made the trainee feel less included in the Practice or had a negative impact on their confidence.

Finally, interviewees talked about their perceptions of effective feedback and teaching during formal tutorials with trainers. Feedback was good when honest, focused and delivered in a sensitive manner but less useful when it did not address training needs or was patronising. Effective teaching offered practical solutions.

5.1 Category 4: Personal qualities of trainer

Summary of category 4- personal qualities of the trainer:

When talking about the personal qualities of their trainers, trainees described their attributes as doctors, in particular, their approaches to patient care and their relationships with and attitudes towards patients. Interviewees commented on whether or not they could relate to or adopt such attitudes and approaches.

Interviewees talked about the ‘approachability’ of their trainers. Trainers were deemed approachable when they were readily available and when trainees were able to approach them without feeling intimidated.

Understanding trainees’ learning needs and assisting them in identifying and addressing them were also reported as hallmarks of a good trainer. Adapting feedback and teaching to the needs of trainees, adaptation to trainees’ learning styles and allowing trainees the freedom to develop their own professional approaches were also considered positive attributes of trainers. When trainers were less adaptable this often restricted professional development.

Length of experience, although commented on when describing the GP trainer, did not seem to affect the training experience except in Practices characterised by hierarchical relationships between doctors where having a junior partner as trainer was suggested to be disadvantageous.

Commitment to and enthusiasm for training, as well as knowledge of the assessment and examination, were also reported as qualities of a good trainer.

5.1.1 Theme 1: The trainer as a doctor

Précis:

Interviewees described the professional attributes of the trainer as a doctor. They commented on the their trainers' approach and attitude towards patient care, their enthusiasm for General Practice and whether or not they were liked by the patients. In describing the trainer attributes as a doctor, they on whether or not they would adopt the same.

Interviewees talked about the professional approach of their trainers to patient care. They often reflected on their own attitudes. For example, Emily (GPT) explains:

'He (the trainer) liked things like psychiatry rather more than sort of just different aspects, um, things like, not over investigating old people, not putting everybody on really, really high amounts of blood pressure tablets, and then they all fall over [laugh] that was an accusation that was levelled, which had a certain element of truth to it. So, it's just different styles, but we were a little bit more alike, I think, in the style that we worked.'

Trainer's enthusiasm for General Practice and ability to manage multiple responsibilities as a GP partner and trainer were also commented on. In addition, a number of interviewees talked about the 'place of the trainer' within the Practice team and the amount of influence the trainer had on the way the Practice operated. The extent to which the trainer was respected and liked by patients was also frequently mentioned. For example, Oliver (GPT), Sabil (GPT) and Sarah (ECGP) all suggested that their trainers were highly regarded and liked by their patients while Eleanor (ECGP) and Judith (ECGP) described a more distant relationship between their trainers and patients. Eleanor explains:

'She (the trainer) certainly had a lot of patients who had mental health problems, so she clearly did do that job well but I think only certain people would perhaps have warmed to the manner. It was slightly different.'

Interviewees noted a number of trainer attributes which they adopted or were trying to adopt. These related to manner with patients, consultation styles, communication skills, relationships with and attitudes towards patients and a general approach to

work. For example, Oliver (GPT) described how he was trying to adopt his trainer's posture and calm manner during consultations, while Judith (ECGP) described her trainer's stricter manner towards patients with addictive tendencies which she respected and adopted. However, some interviewees reflected on attributes or approaches which they did not wish to adopt for example Andrew (GPT):

'She (the trainer) works very hard, but there's been comments from other people about that actually, she's quite chaotic. ...it's actually sometimes not that efficient, it's inefficient – lots of energy but not necessarily always channelled in the right way. So not necessarily someone you want to emulate.'

Interviewees' comparisons between their own values and approaches and those of their trainers perhaps reflect a process of professional development process which involves comparing one own values and attributes to existing role models.

5.1.2 Theme 2: Approachability of trainer

Précis:

The extent to which the trainer was considered approachable to the trainee was commented on by interviewees. Being approachable, easy going, making trainees feel at ease to ask questions were reported as positive attributes.

The trainer being 'approachable' to the trainee was considered a positive attribute of a trainer. Approachability was characterised by ease of access to the trainer even during busy surgeries and by the ability to make the trainee feel comfortable about discussing any training matters without being judged. Many interviews reported their trainers to be approachable (Arvind, Kay, Sarah, Pamela and more). Arvind (ECGP) explains:

'One thing he has got is that he is a very laid back kind of person. He is not that kind of a person who tends to intimidate you, so you can easily approach for any issues either personal or a clinical one. So right from the beginning I've been feeling very comfortable and basically talking about all my issues with him.'

Other interviewees (Eleanor, Andrew, Karen and Raj) did not always find their trainers approachable. When the trainer was unapproachable, trainees had to seek support elsewhere. Eleanor (ECGP) explains how she found hers difficult to approach at times. As a result, she had to seek support from others in the Practice or from her peers. She describes her trainer:

‘Certainly, specifically very confrontational and spiky. Quite difficult occasionally to work with and I guess gauge her moods. There would be times where I would think that I would just hold off till tomorrow to ask that and just let’s not create a situation today. So that was definitely something I found very difficult.’

5.1.3 Theme 3: Understanding of trainee’s learning needs - adaptation of teaching and feedback to needs and adaptation to trainee’s learning style and professional approach

Précis:

Understanding trainees’ learning needs and assisting them in identifying and addressing them were seen as positive attributes in GP trainers. Addressing trainee’s needs often required adaptation of feedback and teaching and an acknowledgement and acceptance of the trainee’s learning style, professional approach and attitude. This enabled the trainee to develop confidently as a professional.

Identifying and addressing learning needs marked out a good trainer. Interviewees talked about the ways in which trainers assisted them in exploring and addressing their learning needs, for example, by agreeing a plan for addressing needs or by guiding trainee’s learning throughout the year.

Oliver (GPT) provided a clear illustration of this by describing how his trainer identified the need for him to shorten his consultations and make them more efficient. She then assisted him in improving his consultations by utilising video analysis and joint surgeries as teaching aids. In addition, as he was poor at organising his own assessments, she helped him by using tutorial times flexibly to complete his assessments.

A further example was provided by Samuel who described how his trainers in his second training Practice adapted their feedback in line with his confidence levels, thus adjusting their critique and support to his needs. This approach enabled him to become more confident:

'When I started, there was a lot of uncertainty, a lot of difficulty with changing Practice and um...sort of the loss of confidence that came with that and my trainer's response was just to be immensely positive and supportive and um...you know...not criticise anything...um...and that very rapidly gave me the confidence I needed and then, you know, then only when I had that confidence did she start to point out things which I needed to build on and at that point I was obviously much more receptive to that if...I think if those pointers had come at a time when I was less confident then I think I would've been far less receptive to them so..in that way they adapted really amazingly well to where I was and ...um...changed their approach depending on my circumstances.'

Other interviewees did not feel that trainers adjusted feedback to their needs. Becca (GPT) described how receiving negative feedback from her trainer while she was already feeling unsure about herself resulted in her confidence being further diminished.

Adaptation of trainer's teaching and approach to trainee's learning style was also reported as a positive attribute of a trainer. For example Alex (GPT) explained how his trainers helped him to learn in a way that suited his learning style. In contrast, Eleanor (ECGP) suggested that her reflective learning style conflicted with that of her trainer's activist approach. Her trainer's failure to adapt her teaching style caused her emotional distress.

Other interviewees, for example, Karen (ECGP) and Gerard (GPT), felt that their trainers did not accept their consulting style or professional approach and that they were expected to adapt their own approach to that of their trainers. This restricted the development of their own professional approach and style.

Gerard (GPT):

'My trainer was, I guess, not quite of the opinion that ever that what she does is the right way, but there's a sort of hint of that, you know, that it must be done this way; as opposed to acknowledging that actually, there's probably as many consulting styles as there are doctors.'

Karen (ECGP)

'And you weren't really allowed to, I think, to develop as an individual as a GP, you had to do it a certain way, I think probably that he thought there was a right way and a wrong way.'

When trainers acknowledged and accepted differences in styles and attitudes, trainees could develop their professional attitudes in a way that suited them. As Emily (GPT) explains:

'He the trainer wasn't ..he didn't try and sort of force me to do certain things or, um, he liked me to go my own way.'

5.1.4 Theme 4: Experience as a GP and trainer

Précis

When describing trainers, interviewees commented on their clinical knowledge and length of GP experience. Level of experience did not seem to affect either the relationship between trainer and trainee or the experience of the trainee in the Practice. It was suggested, however, that having a junior partner as trainer in Practices characterised by hierarchical relationships was a disadvantage as it was difficult for the trainer to instigate changes to training or working arrangements.

Trainer's clinical knowledge (e.g. being up to date) and the trust trainees had in their trainer's clinical decisions were commented on by interviewees. 'Sound' clinical knowledge and decision-making and being an 'experienced doctor' were deemed

positive attributes in trainers. Knowing their patients well was important. John (ECGP) explains:

'He (the trainer) was very current and up to date yeah, when you saw somebody you took a decision and he said hmmm what is the evidence , so it forced you to read abreast.'

Trainer's level of experience did not seem to affect the relationship between trainer and trainee or the experience of the trainee in the Practice. For example both Oliver and Geraldine had inexperienced trainers but did not report that this impacted in a negative way on their training. In addition, conflicts were reported both between new trainers and trainees (Paul) and between more experienced trainers and trainees (Barbara and Karen). Similarly, good relationships were reported between new trainers and trainees (Oliver and Geraldine) and between experienced trainers and trainees (Kay and Pamela). This is described in more depth under the next category.

There was evidence however that in Practices characterised by hierarchical relationships between doctors seniority did affect ability to influence or shape training in the Practice. This was illustrated in the accounts of both Raj (ECGP) and Samuel (GPT). Raj felt that his second trainer shared his concern for the solitary and tense working relationships in the Practice but was unable to influence working arrangements because he was a junior partner. Similarly, Samuel explained that the trainer in his first Practice was a new partner and trainer and so could not instigate timetable changes without a senior partner's permission.

5.1.5 Theme 5: Commitment to and enthusiasm for teaching and knowledge of the assessment

Précis:

A number of interviewees commented on the extent of trainer commitment to and enthusiasm for training. Putting aside additional time to support trainees, assisting trainees in preparation for the examination and knowledge of WPBA requirements were seen as reflections of such commitment.

A number of interviewees talked about their trainers' commitment to training (for example Becca, Sarah, Judith and Alex). They acknowledged the amount of work associated with training and the time their trainers dedicated to it over and above their clinical and managerial commitments. They valued their trainers' commitment to supporting them.

A trainer's ability to tailor formal tutorials to examination preparation was commented on favourably by a number of interviewees. Being properly organised and familiar with what is expected of the trainee throughout the year, particularly in relation to e-portfolio, WPBA and examination were also suggested to reflect such commitment. Michelle's (ECGP) comment illustrates this view:

'He (the trainer) knew exactly what we should be doing while other people's trainers who possibly weren't sort of filling in the correct part of the e-portfolio and caused some stress for their trainees [laughs] whereas my trainer knew exactly where we should be completing and at what time so that was really helpful.'

Nevertheless, the interviews with Karen and Becca illustrated that having a committed trainer did not necessarily translate into a positive training experience.

5.1.6 Key issues of category 4 –personal qualities of the trainer

- Interviewees described the professional attributes of their trainers and reflected on whether they wished to emulate their approaches and attitudes.
- Being approachable was a positive attribute of a trainer. Approachability was judged by ease of access to the trainer even during busy times and by the ability to ask questions without being judged.
- Understanding trainees' learning needs, directing them in addressing these needs and adapting teaching and feedback to needs were positive attributes of trainers.
- Acknowledging trainees' learning styles and accepting their professional attitudes and approaches allowed trainees to develop as professionals.
- Good clinical knowledge and being an 'experienced doctor' were reported as positive attributes of trainers.
- Length of training experience did not necessarily impact on training or on the relationship with the trainee.
- In Practices characterised by hierarchical relationships between doctors, having a junior partner as trainer had a potential impact on training.
- Commitment to and enthusiasm for training were viewed as positive attributes but did not always result in a positive training experience.

5.2 Category 5- Trainer- trainee relationship

Summary of category 5 –‘Trainer-trainee relationship’

This category covers a number of themes, namely, ‘personal relationship with trainee’, ‘honesty and trust in trainee-trainer relationship’ and ‘conflict between trainee and trainer’.

Interviewees commented on whether or not they had a personal relationship with their trainers. A good personal relationship fostered support; its absence reduced trust and respect. Trusting and honest relationships, which were valued by trainees, encouraged the sharing of uncertainties in relation to patient care and thereby provided learning opportunities as opposed to non trusting relationships which discouraged this. In honest and trusting relationships, trainers were more comfortable sharing their own uncertainties with trainees. Non trusting relationships impacted on trainee’s confidence.

A number of interviewees described difficulties during their training. Such difficulties were often due to ‘conflicts’ of ethos between trainee and trainer and/or Practice. At times, these were exacerbated by the trainer’s manner or undermining behaviour. Such conflicts were characterised by poor relationships between trainee and trainer and resulted in an inappropriate response to the trainee’s emotional state, a lack of understanding of the trainee’s needs and a restriction of the trainee’s professional development.

Conflicts often occurred where the trainer found difficulty in acknowledging and respecting differences in ethos. Trainees developed a variety of approaches for dealing with such conflicts. Conflicts demoralised trainees and often introduced doubt or reduced confidence in their abilities. They also resulted in trainees feeling less ‘included’ in the Practice.

5.2.1 Theme 1: Personal relationship with the trainee

Précis:

The nature of the personal relationship between trainee and trainer was often commented on by interviewees. Being able to relate to the trainer on a personal level fostered good relationships and left the trainee feeling supported. However, having a personal relationship with the trainer was not important to all trainees. A good personal relationship was reciprocal and less hierarchical while a poor relationship was often hierarchical.

A number of trainees have commented on the personal relationships they had with their trainers. Some like Judith and Alex developed friendships with their trainers, while others reported a good supportive personal relationship (for example Kay, Sarah and Pamela). Treating the trainee as a ‘person’ rather than merely a trainee, showing concern for the trainee’s wellbeing and taking an interest in the trainee’s personal life were all seen as reflections of such personal relationships and as the signs of a good trainer.

Alex (GPT) explains:

‘And basically obviously looking after you as a person, rather than just as a trainee, you know, so for example they will ask you out for a beer or round to the house for some food, or take you out and play golf or whatever. They are real people rather than just trainers as well. He (the main trainer) can’t ever do enough for you in terms of looking after you on a personal level as well as a professional level.’

Being able to relate to the trainer, having similar interests and liking the trainer ‘as a person’ also assisted in the development of a good relationship (e.g. Alex and Felicity accounts). Having good personal relationships with trainers made trainees feel supported, encouraged them to share their difficulties and assisted them during hard times. Fatima (ECGP) illustrates the point:

‘And I thought that was quite useful because, it was very easy to speak to her if there were any problems I had with patients.’

However, not all trainees reported good personal relationships with their trainers. Raj (ECGP) described a formal relationship, while John (ECGP) noted that he had a good working relationship with one trainer and a personal supporting relationship with the other. Both Barbara (GPT) and Gerard (GPT) suggested that not sharing a common ethos with their trainers resulted in less intimate, personal or supportive relationships, characterised by hierarchical nature. Gerard describes it thus:

'It's always been very top down, she's the trainer, I'm trainee; um, less of a...if you like, a mutual collaborative approach.'

In such relationships there were fewer opportunities to do joint consulting where trainer critic trainee's consultation and trainee critic trainer's. In contrast, good relationships fostered reciprocity (this was illustrated in the interviews with Erica and Geraldine).

5.2.2 Theme 2: Honesty and trust in trainer-trainee relationship

Précis:

The extent to which relationships between trainee and trainer were honest, open and trusting was discussed by interviewees. Trainees valued honesty about their performance. In addition honest and trusting relationships encouraged trainees to implement advice from the trainer and to discuss uncertainties in relation to management of patients. In honest and trusting relationships, trainers more readily admitted lack of knowledge, making trainees feel comfortable with their own uncertainties. Less trusting or honest relationships affected trainee confidence and reduced learning opportunities.

Good relationships between trainee and trainer were characterised by honesty and trust as illustrated in a number of interviews (Alex, Arvind, Emily, John, Judith, Kay, Michelle and Sange). Interviewees talked about the importance of their trainers being honest with them about their clinical performance and progress through the year. Having a trusting relationship increased the trainee's confidence, value and trust in the trainer and their advice. Kay (GPT) explains:

'When he did have points to improve on or criticisms, I felt it was very easy to take that from him because I have 100% confidence in what he did and his opinions, so I would never think he said something to me I would never [emphasises] think well, that is unfair...I felt because I valued his viewpoint and trusted his judgement, it was easier to go, "Right well I need to take that on board".'

In addition, a trusting relationship provided safe ground for the trainee to discuss uncertainties in regard to patient care, without this being seen as a sign of weakness and without the fear of being judged (this was illustrated in Alex's and Kevin's accounts). This fostered better opportunities for learning. Trainers were more likely to admit to a lack of knowledge, making trainees feel more comfortable about their own shortcomings and uncertainties (this was illustrated in Grant's, Erica's, and Geraldine's interviews).

In contrast Karen (ECGP) did not have a trusting relationship with her trainer. She described how she was unlikely to share with him her uncertainties in relation to patient care:

'If I approached him a couple of times about someone with heart failure, which I did, he would then say you're obviously not very confident in dealing with patients with this or and then he would bring it up at an assessment so I therefore was not very willing to talk about such things [laughs].'

Similarly, both Andrew (GPT) and Paul (ECGP) portrayed a lack of honest relationships with their trainers. Andrew explained that his trainer was not open and honest with him about her own weaknesses and so did not help him to address his own pitfalls which were similar to hers:

'What is it about revealing her own vulnerability that did not happen, which has left me feeling...' [stops] I'm, you know, I'm allowed to be this way, because that's, we all have these things that are our weaknesses and we just have to be aware of them and know how to deal with them and they must never get in the way of patient care. But almost, [laughs] in fact, she actually has a lot of the same weaknesses that I have and she has found her own way of dealing with them. But she wasn't as up front as she could have been.'

Paul (ECGP) gave a disturbing account of a deceitful relationship which shook his confidence dramatically. In Paul's case, the untrusting nature of the trainee- trainer relationship was a result of their conflicting view on risk management. In order to support her argument that Paul took too much clinical risk, his trainer alleged that she had had verbal feedback from colleagues who shared her concerns. As these colleagues had not previously raised such concerns with Paul, the allegations made him doubt his ability to gauge people's perceptions of him and reduced his confidence in his clinical abilities. He later found the allegation to be unfounded.

5.2.3 Theme 3: Conflicts

Précis:

Difficulties during training or a negative training experience were often the result of a lack of congruence between trainee and Practice/ trainer ethos.

Having a personal ethos in conflict with that of the Practice left the trainee feeling less included in the Practice. Such conflicts were often due to the trainer or Practice not accepting or acknowledging differences in ethos and their inability to adjust their approach to that of the trainee. Conflicts were often demoralising and affected trainee confidence making the training experience less favourable. Trainees utilised a variety of strategies to deal with conflicts.

Although conflicts had a negative impact, they did not always seem to affect trainees' perception of being prepared at the end of the training year.

Barbara (GPT), Gerard (GPT), Paul (ECGP), Samuel (GPT), Eleanor (ECGP) and Karen (ECGP) all faced difficulties in their training Practices and portrayed a less than favourable training experience. Table 9, which compares their personal ethos with those of their Practices and trainers, as described by interviewees, illustrates that the difficulties were a result of these differences.

The Table also shows that conflict tended to occur in Practices where trainees did not feel included (with the exception of Paul's case). This may suggest that trainees found it difficult to feel included in an environment whose ethos they did not share.

Table 9: Trainee, Practice and trainer ethos as described by interviewees who experienced difficulties during their training

Trainee	Trainee's personal ethos	Practice ethos as described by the interviewee	Trainer ethos or professional attitude as described by the interviewee.
Barbara	Barbara values a team approach to work, learning together, with money being less important to her. She prefers to work in Practices which serve deprived populations and feels that patient expectations should be challenged. She wishes to pursue a less traditional career pathway in General Practice.	Doctors work in isolation, there is lack of team work and it is difficult to implement any changes (less progressive). The Practice is not inclusive of the trainee. Practice has a strong business orientation and money is important. The Practice serves an affluent population and the focus is on satisfying patient demands rather than challenging expectations. There is a lack of common ethos among doctors and poor relationship with staff.	Trainer is focused on business aspects of the Practice. He has a conservative approach to General Practice career pathway.
Eleanor	Eleanor values team work and learning together. She is empathic and concerned with patients' feelings during consultations. She has a reflective style of learning.	Doctors work in isolation and not as a team and the Practice is not inclusive of trainee. There are strained relationships with staff and tense relationships between the doctors.	The trainer has a direct and at times confrontational manner. She is less concerned with patients' feelings during consultations. She has an activist approach to learning.
Gerard	Gerard values less hierarchical and more democratic and collaborative ways of working between doctors and staff. He believes in a more pragmatic approach to consultation format and has a less reflective style of learning.	The Practice is characterised by hierarchical relationships between the doctors and between doctors and staff. There are tense relationships with employed staff. It has less democratic approach to decision-making and is less 'inclusive' of the trainee. It is less progressive and therefore less inclined to take on board suggestions for change. It has a strong business ethos.	Trainer is reflective, rigid in her approach to consultation style, has hierarchical relationship with the trainee.

Trainee	Trainee's personal ethos	Practice ethos as described by the interviewee	Trainer ethos or professional attitude as described by the interviewee.
Karen	Karen has a more informal consultation style and has a level-headed approach towards patients. Respecting the patient is important to her.	The Practice is characterised by hierarchical relationship between the doctors and between the doctors and the trainee. There is no culture of learning from mistakes (less progressive) and the Practice is less inclusive of the trainee. It has a strong business focus and more formal relationship with patients. The doctors work in isolation rather than as a team.	The trainer has a formal approach to patients. His main focus is on business aspects of the Practice.
Paul	Paul is comfortable with managing risk and believes in delivering what patients need not what they want. He believes in empowering patients.	The Practice is generally less hierarchical and more inclusive of the trainee. It is progressive and is characterised by good team work and good relationships with staff. There are some disagreements among doctors. Generally the Practice has a patient-centred approach, focusing on delivering what patients want.	The trainer has a low level of tolerance to uncertainties and risk, tends to over-investigate patients and focuses on delivering what patients want.
Samuel (first training Practice)	Samuel values a less hierarchical and more democratic way of working. He values a progressive, approach and a culture of learning from mistakes. He has a proactive nature and values learning together.	The Practice is characterised by hierarchical relationship between doctors, is not inclusive of the trainee and is resistant to change. It has a strong business focus.	The trainer delegates responsibilities to patients, can be abrupt and not compassionate.

Conflicts resulted in a poor understanding of trainees' needs and a consequent lack of support (illustrated in Barbara's interview), demoralised trainees as it restricted their freedom to develop professionally (illustrated in Paul and Karen's interviews), reduced confidence (illustrated in Paul, Eleanor, Barbara and Gerard interviews) and even affected patient care (suggested by Paul). Having a professional approach not shared by the trainer was frustrating for the trainee and often resulted in a lack of mutual understanding (Gerard, Barbara and Eleanor). It was also difficult for trainees

to apply the advice given by the trainers as it did not fit in with their personal style (Gerard, Paul and Karen).

Conflicts of ethos:

Barbara's case is described here in more detail as an illustration of the difficulties arising from conflict or lack of congruence between trainee and Practice/ trainer ethos.

Barbara (GPT):

Barbara explains the difference between her own personal ethos and her trainer's in her main training Practice:

'I personally found him quite challenging, mostly because we had nothing in common as in individuals, as in people. I think all of these things are so personal and if I was a football player middle class, um wanted to be a GP from the minute I was born person, I am sure he and I would have got on wonderfully much better but I think, I think, I think both of us don't understand each others' worlds very well...he is a Quality Outcome Framework assessor! That says it all.. for me I couldn't think of anything worse than for him to be a QOF assessor, you know .. so he is business absolutely business driven, um QOF, very interested in making sure that... the contracts are worked exactly how it should be, that they won't get away with anything , sort of thing , you know.'

In contrast she explains her own view:

'I understand that business is important, I understand that these people are self-employed essentially and that you have to make the business work because none of you will make money – I understand that concept but I also know that all GPs earn comfortably and I wouldn't personally put that as the top priority ...I would happily say in an interview that money is not my driver.'

She describes the conservative view adopted by doctors in the Practice which she contrasts with her own and with her wish to work with a more deprived patient population:

'I remember right at the beginning I had a patient in the affluent Practice talking to me about her concerns about sexually transmitted infections and I was asking her

*about her sex life and it turns out she had a female partner and that she and her female partner had been using sex toys and I asked them (the doctors) for advice about what I should be doing, and the partners were just so like **oh my god and so embarrassed**, and I just thought this is the real world this is quite normal actually you know, and I think the same would be the case if they (the doctors in the main training Practice) went to some of these houses(in the other training Practice which was in a deprived area) and saw the chaos that people live in, so at some level it is social awareness, if you live in xxx(name of affluent area)-- and you work in xxx (name of affluent area)- and you never choose to go outside of it, then you do have a different life view I think.'*

A further illustration of a conflict of ethos is provided by Barbara's description of a formal complaint against her from an elderly patient and of her trainer's reaction to it. The patient, who had a sore throat, was unhappy about a telephone conversation with Barbara who was trying to assess the need for a home visit. Barbara felt she was not supported by her trainer in dealing with the complaint and suggested that this reflected their conflicting views:

'He never said you are doing the wrong thing, he just said that you have to respect people's expectations which I can see to a certain point but I also think that people expectations can be challenged. You can't expect to have everything all the time, it's just not real.'

As a result of the conflict in ethos the trainer did not understand Barbara's learning needs. Despite the fact that Barbara was doing expedition medicine prior to her General Practice training and during it, her trainer had no understanding of her career needs:

'It was one of our last tutorials and he was preparing me to partnership CV, partnership interviews and I was like 'do you think I would want to be a partner?' he said ho maybe not, and I said do you know what my career plans actually are? and he went pink, it was quite funny (laughing) the actual realisation, you don't have any idea do you? He really had no idea what I want to do.'

Lack of understanding and of shared ethos meant that the trainer was not supportive of Barbara. Because he did not understand her, he was not aware of the emotional distress he caused her and how he made her doubt herself thus affecting her confidence:

'I did question myself a lot, I was upset by what he said a lot, more than he would realise, he would have no idea, he would have me in tears lots of times, he would have no idea of that at all.'

As she received inconsistent messages from her trainer regarding her ability to pass the college examination which she later passed, she sought feedback from other partners in the Practice to boost her confidence.

Trainer's manner or undermining behaviour:

Lack of congruence between trainee's own personal ethos or style and that of the Practice and trainer were sometimes exacerbated by the trainer's manner and undermining behaviour. Karen's case is described here as an illustration of such difficulties.

Karen (ECGP):

Karen describes her trainer's attitude towards her as demoralising:

'I think the main thing was that he just, I don't know [laughs] maybe he wasn't the most sensitive guy and the way he would work things, I felt like he was constantly putting me down and I'm someone who puts in an awful lot of effort.'

She explains how the trainer was overcritical of her performance:

'We had like our half day release group would meet and I you know, I would take things like a video that we had to take and I would get great feedback about it, that it was brilliant and I would show it to him and I would get, you know, fine at best feedback but the exact same video, which I felt was just so unfair.'

His consulting style was different to hers. She explains how he was not accepting of her own style:

'But I wouldn't consult with him twice. Just because I felt his manner was so formal and so awkward. He would say things like "Can you please take your shoes off", "now can you please put your shoes back on", it was just all very formal. You know, I felt anxious watching. I think really you know, that he maybe just likes IT, everything

has a right and a wrong. There's a certain way to do everything, it's all very, you know his manner is very polite and direct.'

Her trainer did not accept her approach to patients, thus restricting the development of her own consultation style:

'I used the word "Wee", like "if you can lift up your top I'll have a wee look at your chest". And he, afterwards, fed back to me that he thought that was patronising and that's the way you speak to children.'

She describes her trainer's professional approach to be different to her own. For example, she discussed with him a problem she had with one of her adult patients who preferred to consult jointly with her mother. She found her trainer's advice difficult to implement due to their divergent approaches:

*'He would offer solutions that I would just **never** do. So I asked him about that patient and he just "save it. A grown adult should just leave the room." And I just felt that it wasn't the way I would deal with someone and not the way that I felt would actually be appropriate for me to deal with... But I don't think that's going to be really helpful for the future so I just nodded and did it my way.'*

She also felt that he was not sensitive:

'You could have awkward conversations with him and he would insult you or other members of staff, not meaning to, but I think maybe his insight was, like, I don't think he was aware he was making some patients very uncomfortable.'

These ongoing difficulties with her trainer left her demoralised:

'I was completely demoralised after the first couple of months, where I would just keep it to myself and battle on. I felt demoralised almost every day [laughs] but I got used to that.'

Karen was very self-driven. She accepted her situation as 'a means to an end' and rationalised the differences with her trainer. In addition, she sought peer support from other trainees and had some support from others in her Practice who were sympathetic to her situation:

'I wanted to progress my career and to do that I just had to get on and kind of suck it up so I just took the comments with a pinch of salt, tried to let it wash over me and got on with the job... I just accepted what he was saying, it was easier that way.'

'I was just coping and everyone used to joke that we were best friends and we got on really well and that I would be sitting next to him on the Christmas night out and everything because we did, I think they were surprised that somebody could get on so well with him [laughs] but actually I thought it was awful but I just functioned.'

Interviewees who experienced conflicts described various approaches to dealing with them: changing consultation style during assessment to fit in with that of the trainer (Paul, Gerard); accepting differences and choosing not to disagree or argue over them, seeing training as a means to an end (Karen); rationalising and working out why differences exist (Karen, Paul and Gerard); gaining support from peers, for example during weekly or monthly educational programmes provided to GP trainees (Karen, Paul); and seeking the opinion or support of other doctors in or out of the Practice (Barbara, Paul, Karen and Eleanor).

Nevertheless, differences in style or professional ethos did not always lead to a 'conflict' between trainer and trainee (for example, in the cases of Geraldine and Raj). This was either because the trainer was accepting and accommodating or because the trainee adjusted approach to that of the trainer.

Finally, although conflict had a negative impact on trainees during training, it did not seem invariably to affect the trainee's perception of being prepared at the end of the training year. For example both Karen and Paul, who experienced substantial difficulties in their Practices, applied and gained partnership posts on completion of their training. This suggests that the personal capacity of the trainee also plays a role. For example, Karen describes herself as being brought up in a 'humble background' and as being self-driven. Paul embarked on a medical career as a mature student and his previous employment had involved risk-taking on a daily basis. It is therefore possible that such trainees were particularly resilient in the face of the negative pressure of their training environment.

5.2.4 Key issues of category 5- Trainer-trainee relationship:

- Good personal relationships with trainers, which left trainees feeling supported, were typically reciprocal and often personal rather than formalised and hierarchical.
- Honesty and trust between trainee and trainer were important to GP trainees and supported their learning. Lack of honesty and trust affected trainee's confidence and learning opportunities.
- Difficulties during training occurred primarily as a result of trainee ethos being in conflict with that of Practice and/or trainer. Such conflicts resulted in the trainee feeling less included in the Practice and limited the opportunities to fully participate in Practice work.
- Conflicts often resulted in a lack of understanding of trainees' learning needs and inappropriate levels of support.
- Conflicts were demoralising for trainees and at times restricted professional development. Trainees had to adopt varied coping mechanisms to deal with conflict.

5.3 Category 6- The teaching

Summary- the teaching:

When talking about the formal teaching sessions (tutorials) with the trainer which occurred throughout the year, trainees described the feedback given during these sessions. Receiving encouraging feedback increased trainee's confidence. Good feedback was honest, to the point and critical without undermining confidence. It provided practical solutions and set clear expectations for trainees of what they were expected to achieve. It assisted trainees in improving performance and provided reassurance. Consulting jointly with trainers was identified as a useful teaching tool.

Feedback was considered to be less useful when it was delivered in a rigid format as it did not address trainee needs (for example, for support or a focused solution). Being overcritical damaged confidence, particularly when the trainee was lacking confidence. Criticism was not well received when it was given indirectly, presented in a patronising manner, unclear about ways to address identified problems or delivered in an inappropriate place and time.

Challenging trainees during tutorials was viewed both positively and negatively. The findings suggest that challenge needs to be tailored to trainees' needs and level of confidence and should be balanced by support.

5.3.1 Theme 1: Effective teaching and feedback

Précis:

Encouraging feedback from the trainer increased trainees' confidence in their own abilities. Direct, honest feedback on performance, particularly when identifying clinical mistakes, was valued by trainees. Interviewees also highlighted the need to deliver negative feedback in a sensitive manner. Good feedback was specific, outlined clearly what was expected of the trainee and offered practical solutions. Consulting jointly with trainers was a useful educational tool for improving consultation skills and for exam preparation.

Receiving positive feedback from trainers was described as ‘empowering’ and ‘encouraging’, and increased trainees’ confidence in their own abilities. Good feedback was ‘honest’ and delivered criticism in a sensitive manner without damaging or undermining confidence. For example, Andrew described the feedback on a recorded consultation in his second training Practice, to which he was attached to for a short period of time:

‘I don’t know why, but for some reason the way he said those things for that specific ...environment...it was also that he did it in a very non-threatening way, which I think was important. I didn’t feel worried about his feedback and he fed back in a way that didn’t make me feel negative in any way. And perhaps in the past some of the comments have left me feeling maybe a bit down about myself in the way that they’ve been fed back.’

Some interviewees valued direct and honest feedback from their trainers which pointed out what needed to be done to improve performance. For example, Sange (ECGP) describes how his trainer’s honest and specific feedback on his consultations assisted him in passing his CSA examination. Good feedback was constructive and specific, giving practical suggestions on improving performance (e.g. practical tools for improving consultations). Conversely, Becca (GPT) describes how feedback without clear action points left her unable to improve her performance.

‘We did, we did sometimes have discussions, but I think I didn’t always come away knowing, still feeling very clear about what it was that I was, that I was missing out on, or I was missing.’

In contrast she explains that when she received clear and explicit feedback as to what she was expected to achieve (from her second trainer), she was less anxious:

‘So like for instance now, one of the things he (second trainer) did was he looked at my referrals as it shows how a doctor manages uncertainty, and then he did this chart thing where he talked about, you know, where you could be and you could be unhappy with uncertainty or quite satisfied with uncertainty, and how you know you should be aiming to be and he had statistics of everybody and it’s very clear. I know where I am. I know what’s expected of me. I don’t feel like there is any expectations up there that I don’t know how to meet, I feel clear, I feel, you know, I don’t feel worried.’

Similarly a number of trainees reported on the usefulness of consulting jointly with trainers. Watching the trainer consult enabled the trainee to pick up useful comments and communication techniques, particularly helpful for examination preparation. Erica (ECGP) explains:

'Certainly watching him (the trainer) consult I realised how it's made me better now to be picking up on the social and psychological cues for the patient.'

5.3.2 Theme 2: Less effective teaching and feedback:

Précis:

Feedback was less useful when it was delivered in a rigid format as it did not always address trainees' needs. Feedback was not useful when it was delivered in a patronising manner, was not specific or was given unexpectedly.

Rigidity in the format in which feedback was delivered was suggested at times to detract from its usefulness. A rigid format of feedback (e.g. Pendleton style of delivering both positive and negative aspects) did not always address trainees' needs. For example Samuel (GPT) described how the rigid way feedback was delivered to him, always pointing out negative as well as positive aspects, did not enable him to gain the reassurance he needed at a time when he was lacking confidence. Similarly, Gerard (GPT) explains how rigid feedback on WPBA did not address his needs:

'If you've had a particularly bad consultation, and you know you've had a bad consultation, and that's one of the reasons that you're doing this as a COT, is because you would like some actual feedback, and you don't particularly want to know what you've done well, you don't want to think, okay yeah, I did do that well; but actually, I want to focus on what I didn't do well. Because most of the time, you'll know it was crap and you maybe need someone to acknowledge, yes, that wasn't great, let's think about what wasn't good about it and what you might do differently.'

Criticism of a good consultation was viewed by some as 'nit picking' and even undermined confidence as Samuel (GPT) explains:

'Because, you know, even when I felt something was done really well and even when it was agreed that it was done well there would always be some comparison or something and it wasn't a sort of...wasn't very confidence building, the way he did it and I always felt in some ways a sort of mixed message. So at times when I really needed help to feel confident that's the last thing that I got.'

Criticism was not well received when it was indirect, such as feedback from others delivered via the trainer or given in a patronising fashion. Finally Paul (ECGP) highlighted that feedback needs to be delivered at a mutual agreed place and time. His account illustrated that delivering negative feedback to trainee who is unprepared can be damaging to confidence:

*'She (the trainer) would often find that if there were little things that had been niggling her she wouldn't challenge them necessarily at the time in fact she might save them up until she got a batch of them....and then she'd sort of plan about how she wanted to broach you about it for a week or two in advance till it was quite clear and she'd got her, sort of, order of battle ready and then she'd catch you unawares sometime when, you know, perhaps you'd just seen twenty patients and it was six o'clock and you were just thinking 'Oh – I'll sort out these two referrals, write up the last three consultations that I didn't have time to do as I was running late and then I'm going home **coz I'm shattered**' and, you know, she'd come and plonk herself down in your room, open the floodgates of verbal diarrhoea and make you feel about as low as a snake's butt in a wheel rut afterwards.'*

5.3.3 Theme 3: Challenge

Summary:

A number of interviewees commented on the degree of challenge during their formal tutorials with trainers. Some felt that being challenged was good for their learning. However, challenge was not well received by trainees who felt the need to be supported. Challenging a trainee lacking in confidence, without the provision of reassurance had a negative impact on their confidence.

Interviewees reflected on the degree of challenge during formal tutorials. Challenge during tutorial was seen to be good for learning as it encouraged trainees to consider different diagnoses and management plans as well as the evidence underpinning any

decisions they were making. Tutorials therefore provided protected time for trainees to reflect on their own medical practice with guidance from the trainer.

However, being challenged during tutorials was not welcomed by all trainees. For example Grant (ECGP) felt that he required support rather than challenge to deal with the heavy level of workload in his Practice:

'I don't think your trainer needs to challenge you. I mean, the work was challenging, the diversity of things that you were seeing was challenging, the experience that you had of primary care was challenging. You know, there were enough challenging aspects of the job without my trainer setting me tasks.'

This suggests that the level of challenge needs to be adapted to the needs of trainees. Challenging trainees' clinical decisions during tutorials without providing them with the reassurance they needed was viewed as confrontational and reduced confidence. This style of feedback had a negative effect as it introduced doubt about the trainee's ability and created a reluctance to share uncertainties with the trainer. Eleanor illustrates the point:

'It was part of the questioning, I think. It was very direct. "So why did you do this, why do you find it so difficult?" vaguely pushing, pushing, pushing and I think pushed me just a little too far. And I think that a lot of the time it did, I don't want to be dramatic, but I would think "should I know all of this? Am I working hard enough, am I not cut out for this?" So I would start to introduce little doubts and I wasn't in top spec that year – I was fine, but I wasn't great. So it would introduce doubts in my mind and it also did make me reluctant to divulge too much.'

5.3.4 Key issues of category 6-the teaching:

- Effective feedback delivered criticism without undermining confidence and provided specific, practical suggestions with clear action points. Joint consultations with trainers assisted in improving consultation skills.
- Feedback was less effective when delivered in a rigid format without taking into account trainee's needs, when it was less specific and when it was delivered in a patronising manner or unexpectedly.
- Challenge during tutorials facilitated learning but needed to be balanced with appropriate support.

Chapter 6: Findings- Construct 3 ‘preparedness’

Introduction

This Chapter describes the various meanings that GP trainees and early career GPs attach to ‘preparedness for Practice’ and the ways in which they perceive the training environment to impact on preparedness. Preparedness is therefore described from the interviewee’s perspective rather than related to any theoretical perspectives on preparedness.

There was no unanimous way by which interviewees described preparedness. Rather initial analysis of the various meanings attributed to preparedness and the ways interviewees perceived their training environment to impact on preparedness yielded 71 codes (see Appendix 7). Preparedness emerged as a third construct and the second stage of the analysis (Chapter 3 p.85) generated seven themes describing that construct. In addition, drawing on the themes identified in Chapters 4 and 5, this Chapter discusses the ways GP trainees and early career GPs perceived their training environment to impact on their preparedness. The findings from interviews with doctors in training are presented together with those from early career GPs as there were very few differences between the two groups.

The meanings attached to preparedness for Practice is thereby described under the following seven themes, each theme representing a different aspect of preparedness:

- Working independently and being self- directed
- Confidence
- Knowledge of business aspects and partnership issues of General Practice
- Adaptability
- Patients and workload
- Consultation skills and time management
- Knowledge base and passing RCGP CSA examination

The way in which the training environment was perceived to impact on these different aspects of preparedness is also described under each theme.

Overview:

Chart 2 (p.188) provides a visual summary of the different meanings that GP trainees and early career GPs attached to 'preparedness for Practice' and presents the relationships between the various meanings. It illustrates that there were two central themes describing preparedness ('confidence' and 'adaptability') with the other identified themes, relating to these central themes.

Preparedness was described as an ongoing process of gradual self-realisation rather than one with a finite end point. It was described as self confidence in one's own ability to manage patients, make clinical decisions and take responsibility for patient care. Confidence was also reflected in a clear notion of expectations from future working environments. The trainer's belief in the trainee's ability, feedback from others, particularly other doctors, and overcoming difficulties during training all contributed to a feeling of confidence. The trainer who helped the trainee to identify and address learning needs and adjusted feedback, support and challenge during tutorials accordingly, assisted in building confidence. Relationships lacking trust and honesty or conflicts between trainee and trainer at times impacted negatively on confidence. Support from the Practice in dealing with significant events or complaints enhanced confidence.

The ability to adapt to and work in various environments was also described as an indication of being prepared. Training in more than one Practice was reported to be advantageous as it enhanced adaptability through observation of a variety of ways of working and of approaches to clinical practice. Having a good knowledge base and sound decision-making processes, working with different patient populations and possessing diverse consultation skills further aided adaptability.

Working independently and unsupported, being self-directed in seeking solutions, and taking responsibility for patient management and one's own continuous professional development were all markers of preparedness. Being 'trusted', while being supported or guided in decision-making, encouraged self-direction and consequently increased confidence of GP trainees in their own abilities. Appropriate levels of supervision were also important in fostering security and independence. The theme 'working independently and being self-directed' therefore relates to the theme 'confidence' as Chart 2 illustrates.

Knowledge of business-management aspects of General Practice and an understanding of partnership dynamics enhanced the feeling of being prepared. Being actively included in meetings and discussions relating to business-management issues increased the confidence of trainees in their ability to manage these aspects in future. Therefore, the theme 'knowledge of business aspects and partnership issues' also relates to the theme 'confidence'.

Being able to manage complex and unexpected cases, as well as a heavy workload, having a concrete notion of the role of a GP in relation to patients and taking into account social influences on patient management were all reported as indicators of preparedness. Opportunities to manage medically complex patients, variety and diverse clinical cases and challenging patients and presentations were deemed preparing. Successfully managing such cases, made trainees feel more confident in their abilities. The challenges associated with working with either deprived or affluent populations were also described as preparing, making trainees feel more confident and adaptable to working in different Practices. In addition, when trainees were able to manage heavy workload this increased confidence and the perception of being prepared in contrast inability to manage workload reduced confidence. The theme 'patients and workload' therefore relates to the themes 'adaptability' and 'confidence' as illustrated in Chart 2.

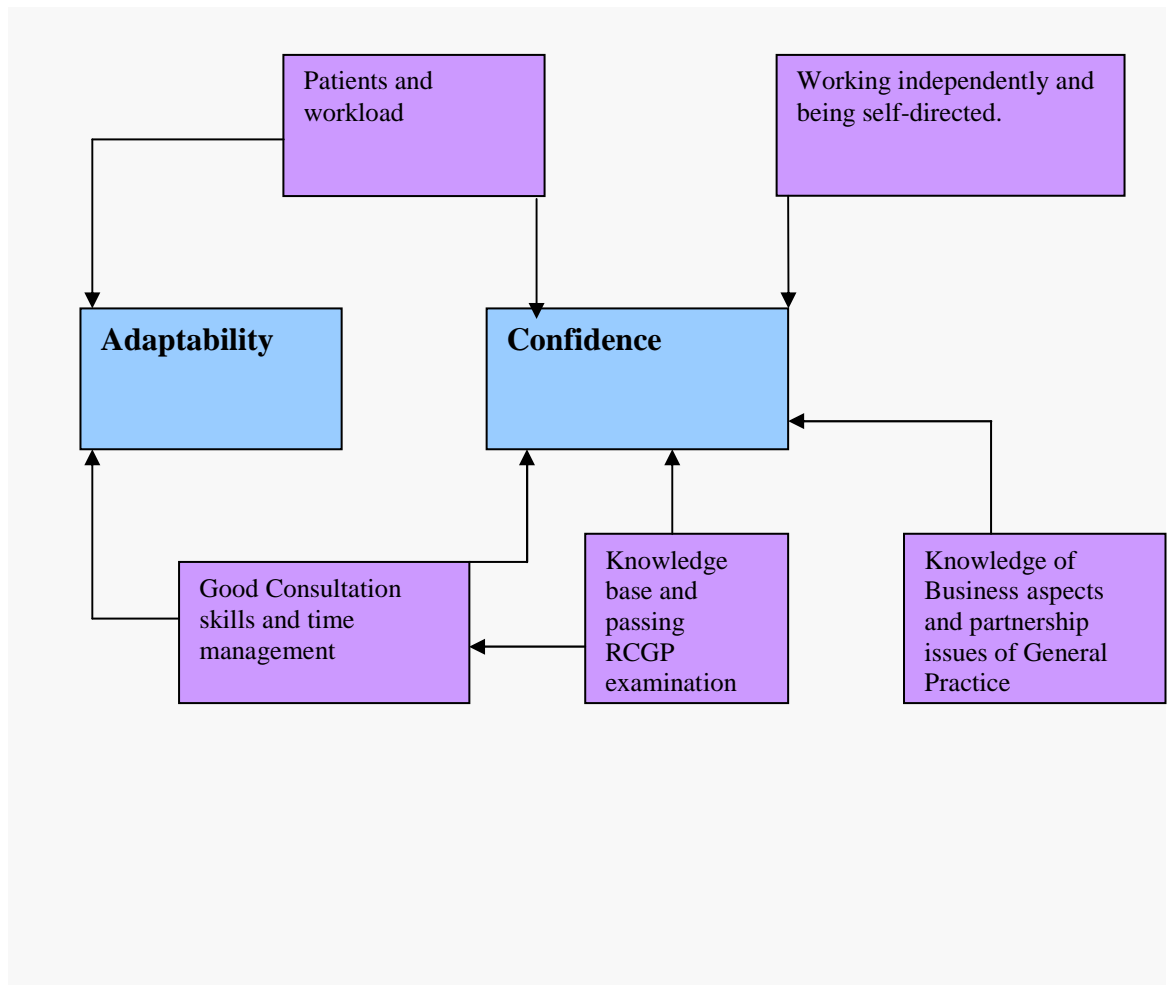
Preparedness was also described as having consultation skills which enable one to manage diverse patients and the ability to manage clinical and administrative tasks in

a timely manner. Having a variety of consultation techniques enabled doctors to adapt easily to future employment. Not being able to manage time well reduced confidence in the ability to manage General Practice work. The theme 'consultations skills and time management' therefore relates to the themes 'adaptability' and 'confidence'. Constructive and specific feedback from trainer enabled trainees to develop good consultation skills.

Passing the Royal College examination was also reported as an indication of being prepared and enhanced confidence in the ability to practise independently. A broad knowledge base was suggested as a necessary foundation for consultation skills and decision-making and to increase GP trainees' confidence in managing patients. The theme 'knowledge base and passing RCGP CSA examination' therefore relates to the themes 'confidence' and 'consultation skills and time management'.

The last section of the Chapter illustrates the way the theme 'inclusion', described in Chapter 4, relates to the concept of preparedness. It is suggested that inclusive Practices provided better training environments as they promoted both 'confidence' and 'adaptability', the central elements of preparedness. Finally, Chart 3 (p.219) provides a summary of the ways the training environment impacts on the elements of preparedness.

Chart 2: What meanings do GP trainees and early career GPs attach to preparedness for practice?



6.1. Theme 1: Confidence

Précis:

Many interviewees described being prepared as a feeling of confidence in one's own skills and decision-making in managing patients. Having an 'approach' for dealing with unexpected clinical situations and being aware of one's own limitations contributed to a feeling of confidence. Becoming confident was described as a process which evolved over time. Experiencing difficulties during training and overcoming such difficulties increased confidence in one's abilities to deal with the reality of General Practice.

Confidence was enhanced when trainees received positive feedback from doctors and patients. The trainer's belief in and positive feedback to the trainee particularly enhanced confidence. Experiencing significant events or dealing with clinical errors during training supported preparedness if the trainee was supported by the Practice. Lack of support reduced confidence in dealing with such situations in future. Untrusting relationships between trainer and trainee affected trainee confidence. The degree of challenge trainers employed during tutorials and the extent to which they assisted trainees in identifying and addressing their learning needs also impacted on trainee confidence.

Many interviewees described preparedness as a 'sense' or a feeling of confidence in one's own skills and decision-making. Such confidence was often derived from having an 'approach' for dealing with clinical situations and managing risk. For example Kevin (GPT) talks about preparedness:

'I suppose I would say that I have confidence in the skills that I've developed, that I can perform very well in this role and I can deal with any sort of unforeseen circumstances or unforeseen clinical situations or I have an approach to dealing with things that I don't know or an approach to dealing with problems. Confidence in the ability to find an approach to deal with something that's unfamiliar.'

In addition, a number of interviewees suggested that confidence was derived from a sense of self-awareness - an appreciation of one's limitations and boundaries and of how to handle them. Being overconfident was deemed dangerous, as Geraldine (ECGP) explains:

'It's about feeling confident about seeing patients and knowing your limitation. I wouldn't say I was entirely comfortable but then again I never will but, I feel there will always be more to learn. But again that's just my personality. I would probably be dangerous if I did feel that I knew everything'

Confidence was also reflected in other ways, for example, by being 'decisive', by being comfortable with a lack of knowledge or by feeling at ease admitting such a lack to patients.

A number of interviewees thought that confidence levels develop over the course of the training year. Confidence was also reflected in the way interviewees talked about the elements that were important to them when seeking employment. Having clear expectations from future employment can be viewed as an aspect of confidence.

In addition, a number of interviewees suggested that experiencing difficulties during training, such as significant work pressures and challenging personal circumstances, was painful but also prepared one for real life in General Practice. They suggested that it enabled them to learn how to deal with difficult situations thereby increasing their confidence in coping with such situations in future.

The impact of the GP training environment on confidence

The trainer's confidence in the trainee confirmed or enhanced the feeling of being prepared. For example Becca (GPT) described how her trainer's belief in her enhanced her own belief in herself, while Alex (GPT) explained how his trainer's satisfaction with his performance provided confirmation for him that he was prepared for independent practice. Having loyal patients also enhanced the feeling of confidence.

In contrast, a trainer's lack of confidence in a trainee's capabilities introduced doubt, as Andrew explains:

'It almost at the time, I was being told "I don't have confidence that you're going to manage independently", Which just reinforced my own kind of slightly negative view of myself that I wasn't ready and that I wasn't good enough.'

Receiving positive feedback from other doctors on their performance increased trainees' confidence in their own abilities. This issue was raised by many interviewees. For example, Paul (ECGP), Karen (ECGP) and Barbara (GPT), who felt undermined by their main trainers, described how receiving feedback from other doctors enhanced their confidence. Indeed both Paul and Karen went on to take up a permanent salaried post and a partnership respectively on completion of their training while Eleanor, who did not report receiving much positive feedback from other doctors, was working as a locum.

Andrew (GPT) described how receiving positive feedback from a trainer in another Practice to which he was attached for a short period gave him a 'confidence boost'. This, together with his ability to cope with the workload, made him feel confident about himself and improved his decision-making and consequently his confidence in applying for partnerships.

In addition, several of the themes describing the training environment outlined in Chapters 4 and 5 explain the ways in which the training environment can impact on confidence:

1. 'Caring and support for trainee' (described in section 4.3.3)

The theme 'caring and support for trainee' explains how the Practice support of trainee was illustrated in the way the Practice responded to significant events or difficult situations the trainee encountered. Being supported by the Practice, when making a clinical error or during a significant event, enabled trainees to regain confidence in their own abilities. Lack of support reduced confidence in dealing with

such situations in the future. For example Sabil (GPT), who experienced a significant event in relation to drug overdose, explained that the support from his Practice and trainer assisted him in regaining his confidence. This was in contrast to Barbara (GPT) who was left to respond to a patient complaint with little support from Practice or trainer. She explains how this reduced her confidence in dealing with similar situations in future:

'Even if you feel you have done the right thing, who wants to have a complaint against them, who want.., did I feel absolutely awful , YEH (Loughs nervously) absolutely and did I think Christ am I ever going to be able to say anything to a patient without wondering and worrying that they are going to put a complaint.'

2. 'Understanding of trainee's learning needs - adaptation of teaching and feedback to needs and adaptation to trainee's learning style and professional approach' (described in section 5.1.3)

The theme illustrated the importance of adjusting feedback to the level of confidence of the trainee in order to build confidence further. Respecting trainees' own professional styles or approaches allowed them to develop confidently as professionals.

3. 'Honesty and trust in trainer-trainee relationship' and 'conflicts' (described in sections 5.2.2 & 5.2.3)

These themes illustrated that untrusting relationships between trainer and trainee can affect trainee confidence. Similarly conflicts were demoralising and at times affected confidence or restricted the freedom to develop professionally.

4. 'Effective teaching and feedback', 'less effective teaching and feedback' and 'Challenge' (described in sections 5.3.1, 5.3.2 & 5.3.3)

These themes illustrated that encouraging feedback to the trainee enhanced confidence while ineffective feedback at times affected trainee's confidence. In

addition, the theme ‘challenge’ illustrated the need for a balance between challenge and support during teaching sessions. Challenging trainees without the provision of reassurance impacted negatively on confidence.

6.2 Theme 2: Adaptability

Précis:

A number of interviewees, particularly early career GPs who worked as locum GPs or in temporary jobs on completion of their training, described the ability to adapt to and work in various environments as an indication of preparedness. The need to be adaptable was reported as a challenge by both early career GPs and trainees. Adjusting to different working arrangements in employing Practices was particularly challenging when these contrasted with the doctor’s own ethos and values. Moving from an urban to a rural area was reported as an example of the need to adapt as one had to adjust decision making and skill. Becoming familiar with different IT and referral systems to secondary care was challenging and called for adaptability.

Training in more than one Practice was suggested to enhance adaptability because trainees saw different ways of working, different approaches to clinical care and even different patient groups. Having an adequate knowledge base and sound decision-making processes supported adaptability. Exposure to various legitimate approaches to clinical management enhanced confidence and adaptability, as did experience of working with different patient populations and the development of diverse consultation skills. This will be described in more detail in the themes ‘patients and workload’ and ‘consultation skills and time management’.

Being prepared for practice was described as an ‘ability to adapt’ and to work in different environments by both early career GPs and trainees. The ability to move flexibly between different working environments while doing locuming, was viewed as a reflection that one was well trained.

Judith (ECGP):

'I think the fact you can move around and be quite flexible is a reflection that you can work in different places, that you've been trained well.'

Adjusting to different work arrangements and values in employing Practices following completion of training, was reported as challenging by some early career GPs (Erica, Pamela and Sarah), particularly if work values were in contrast to their own.

For example, Erica (ECGP) identified with the values and attitudes of her training Practice which emphasised and valued team work, shared responsibility and continuity of care. This conflicted with the ethos of her follow-up employing Practice where doctors worked in isolation, placed less emphasis on team work and continuity of care and a greater emphasis on financial gain. Consequently, she found it difficult to adapt to her new employing Practice. Eleanor (ECGP), on the other hand, trained in a Practice with little emphasis on team work. For Eleanor the transition into locum work was easier as her employing Practice had an ethos closer to her own.

A move from working in an urban to a rural area was challenging for Samuel, Emily and Judith who reflected on the need to adapt their decision-making and other skills accordingly. Samuel (GPT), who secured a post in a rural area, describes the challenges he was likely to face:

'In a more rural environment having trained in a, you know, sort of exclusively in an urban environment, um, so that I think will bring its own challenges in terms of different ways of doing things in a more rural area, and in terms of the diversity of skills I'll be required to practice. So I think I'll probably have to diversify in terms of the skills I practice.'

The need to adapt to secondary care service referral systems and relationships with secondary care was also reported as a challenge of future employment as Michelle explains:

'Working in [name of area], for example, with knowing where you refer certain people, just getting used to that system can be a bit tricky as well, cause I was very much used to what the [name of place] system was for referring people.'

What enhances adaptation?

1. Having an adequate knowledge base

Being equipped with appropriate level of knowledge and decision making processes supported consultation skills and made GPs more adaptable to working in different environments, as Eleanor (ECGP) explains:

'Well, I think one of the big realisations when I finished my training was that medicine is the same everywhere. So to feel that you're armed with the knowledge and decision-making processes to still perform that job well, but not necessarily just in that familiar environment. Certainly as a locum, it's a different environment every day. I certainly felt prepared in that way, in terms of the knowledge, absolutely.'

2. Training in more than one Practice

Some trainees felt that having trained in only one Practice was a disadvantage. For example Grant (ECGP), who had done so, reported that it took him a while to adapt to the different ways of working in different Practices when he started working as a locum. Getting used to different IT systems was also a challenge described by early career GPs and a concern for GP trainees as Grant (ECGP) explains:

'I was under-prepared in that I wasn't ready using other computer systems and I hadn't ever encountered any other GP surgeries, so when I went to different Practices, things were done differently and it took me a while to adapt. It took a while to learn the way that other Practices worked and how to fit into that.'

In contrast, interviewees who trained in two different Practices or had the opportunity to spend time in a second Practice during their training felt that seeing different ways of working helped them to be adaptable. Training in two different Practices gave trainees an insight into various ways of working and different clinical approaches to patient management thus, potentially allowing trainees to develop a

more flexible approach to problem-solving and service development. In the cases of Barbara, Samuel and Andrew it also enabled trainees to see two different patient populations. Working in different Practices also aided in shaping work aspiration.

Barbara (GPT) explains how training in two different Practices broadens experience and is thus potentially better at ‘preparing’ trainees:

‘I think the two Practice thing is a benefit actually because you see two different ways of working, you see how two sets of administrative teams work, you see how two sets of reception teams work, you have the inside politics of two different places and you see potentially two very different Practice populations as well. I think that personally it is a broader experience is a good experience.’

‘An understanding that there are other ways of doing things out there, you know, and having the knowledge that it is not just all black and white.’

3. Participation in meetings

The theme ‘participation in meetings’ (section 4.1.4) suggested that inclusion in meetings enabled trainees to take part in professional conversations thereby making them feel more included in the Practice. The theme illustrated that the participation in professional conversations also exposed trainees to various approaches to clinical management and enabled them to see that there are various and legitimate approaches to the management of patients. Consequently this enhances their adaptability to different working environments.

4. Experience of working with different patient populations and having good consultation skills

The opportunity to work with different patient populations (affluent and deprived) and the possession of diverse consultation skills for dealing with different patients aided adaptability. The themes ‘patients and workload’ and ‘consultation skills and time management’ described in sections 6.5 and 6.6, deal with this in more detail. Sarah (ECGP) explains how having diverse consultation skills assists in dealing with different patient populations while doing locum work:

'So you do adapt the consultation skills, and yes, it is different for different Practices, like deprived versus affluent. You change your model slightly to fit the patient who is in front of you and their expectations, but... and I think you do get taught that throughout.'

6.3 Theme 3: Working independently and being 'self-directed'

Précis:

For many interviewees, the ability to work on their own without support was a marker of being prepared. The ability to work on your own was supported by 'self-direction', that is the ability to seek solutions and make decisions on your own thus taking personal responsibility for patient care. Being 'self-directed' was also described as an attribute required throughout one's professional career in order to maintain professional accreditation and further develop skills and knowledge required for general Practice.

Being trusted and being given the opportunity to work independently was deemed preparing when support was readily available. Decision-making was supported when trainees were encouraged to consider alternative solutions or rationalise their own decisions. This made trainees more confident in their ability to work independently. When the supervision level was tailored to trainees' needs it fostered security and independence through reassurance. Working independently and being 'self-directed' therefore contribute to confidence and so, the theme 'working independently and being self-directed' is related to the theme 'confidence', as illustrated in Chart 2.

A number of interviewees described the ability to work on their own towards the end of their training year, without seeking advice or support from others, as a marker for being prepared for work as a General Practitioner. As Grant (ECGP) explains:

'I no longer needed to ask for help so I could quite comfortably go through the whole of surgery, with 10-minute appointments without having to ask for help a lot of the time. So I think "oh, I can go and do this on my own now, I can go on

visits by myself, I could do the duty doctor sessions by myself without anybody needing to help me out”.

In addition, newly qualified GPs suggested that being able to work on your own as a locum without having the support of a trainer in the background was a further confirmation that one was prepared.

When talking about the meaning of being prepared, interviewees spoke about the importance of being 'self-directed'. Andrew (GPT) described how becoming an independent practitioner meant learning to seek solutions for clinical problems yourself. He explained how his trainer discouraged his dependence on her for guidance. He reflected that this process of becoming 'self-directed' was painful but necessary. Similarly talking about being prepared, Pamela (ECGP) explained that, although being 'self-directed' could involve exploring different approaches to clinical management with other doctors, the ultimate decision and consequent responsibilities remained with her. Having a 'system' for dealing with uncertainties and developing problem-solving skills and approaches for managing risk supported self-direction. As Sarah (ECGP) explains:

‘I think the training in itself exposed me to areas that I wasn’t familiar with which is what I was quite nervous about at the start of the year. But I think as you go through things you realise that you don’t have to know everything... that you... so long as you can manage it in a systematic fashion. Erm, you kind of learn those kind of problem-solving skills in a better way, in a more uncertain environment in General Practice.’

Being self directed was also described as a commitment for continuous learning, a motivation to maintain GP accreditation and a desire to further develop as a General Practitioner. Passing professional exams, maintaining continuous professional development (CPD) portfolio, identification of further learning needs and the development of special interests were seen as illustrations of such commitments and motivations.

The way in which the GP training environment supported self-direction

A number of interviewees talked about the ways in which their trainers supported them in making their own decisions. Facilitating trainees to work through their own decision-making was deemed preparing rather than providing them with solutions. This occurred when trainers encouraged trainees to consider a range of alternatives to a clinical problem, helped them to work out the rationale for their decision-making or simply provided encouragement for trainees proposed plans. That approach provided reassurance for trainees and enabled them to become more confident in making their own decisions thus supporting them in becoming self directed. Pamela (ECGP) explains:

'I think from my own learning, it's not actually helpful to be told what to do, it's much more helpful to decide for yourself what you want to do and why you want to do it, but it can be useful to get a bit of feedback on your rationale...and I think that definitely helped my confidence for me to already form a plan and for somebody else to think that that plan was reasonable.'

The following themes describing the training environment, outlined in Chapter 4, illustrate ways in which the training environment supports self-direction:

1. 'Adaptation to trainee's learning needs (described in section 4.3.1)

This theme illustrated that Practices that were flexible (in terms of rota, length of appointments and tutorial content) encouraged trainees to lead on identifying and addressing their learning needs, thus supporting self-direction. Inclusive Practices more readily adapted to trainees learning needs.

Michelle (ECGP) explains how her training Practice encouraged her to choose tutorial topics:

'Well my Practice were so good in that, I suppose as they put it back to me and said "You know you still have, you know a weekly teaching session and what are the gaps in your knowledge that you want to sort of cover?".'

2. 'Supervision' (described in section 4.3.5)

This theme illustrated that when the level of supervision was appropriate to the needs of trainees it fostered security and independence. When describing the aspects of their training environment which prepared them for independent practice, a number of interviewees (e.g.Alex, Erica, Kevin, Grant, Gerard, Geraldine) felt that being given clinical responsibilities and being trusted to make their own decisions, with support being available if needed, was preparing. Kevin (GPT) explains:

'I learn best by doing...by being given a bit of freedom in order to do things and if there's a problem or if I've got questions, being able to ask about that, or look it up. I guess in some Practices there's not the same freedom to be able to just carry on and do the job and learn through experience. So I suppose I benefited from being allowed to just get on and do it and being left to be responsible to get in touch with my tutor if I ran into any problems.'

Nevertheless, this was not the case for Judith and Eleanor who were given responsibility and freedom but were not appropriately supervised and so did not receive the reassurance they required to support their decision-making. Lack of supervision and support resulted in doubt and reduced confidence during training.

However, both Eleanor and Judith (ECGP) reflected retrospectively that this approach encouraged them to make decisions and to seek solutions for themselves. Eleanor felt that it prepared her to work on her own, while Judith felt she learnt to trust herself, however she was inconclusive whether lack of support was indeed preparing.

6.4 Theme 4: Knowledge of business aspects and partnership issues of General Practice

Précis:

Interviewees suggested that the perception of being prepared was enhanced by understanding the business aspects of General Practice, including staff management, finance and partnership dynamics. Being able to manage self-employment was also seen as a necessary requirement for early career GPs.

Active involvement in business or non-clinical aspects of General Practice work by being included in meetings and discussions or by undertaking a management responsibility enhanced the perception of being prepared. Not being involved in the business aspect meant that early career GPs had to learn these skills in follow-up employment. Being aware of the dynamics of partnerships, how responsibilities are shared between the partners and how decisions were made also enhanced GP trainees understanding of partnership demands.

Understanding the business aspects of General Practice was highlighted by interviewees as an important element of being prepared. Interviewees suggested that understanding of business aspects included a number of elements:

Gaining an insight into staff management (e.g. how problems with staff were addressed and how decisions in relation to their work were made), was viewed as part of GP partners work. In addition, having an understanding of the financial aspects of General Practice was also important in preparing trainees for the roles they would be likely to encounter as partners. As Pamela (ECGP) explains:

'I was encouraged to be part of the Practice meetings and that's really useful for a registrar because how on earth are you ever meant , expected to fall into a partnership if you've never even been to a partnership meeting..When they[the GPs] were going through their finances or whatever I will still allowed to be a part of it, which I think is something which shouldn't be undervalued, I think it's important to understand.'

Similarly Samuel (GPT) describes how useful it was to observe business management aspects in his second training Practice:

'I think it was good to see, ah, the side of business management which was particularly efficient and good to see how they, what strategies they used to optimise their profits and, ah, you know, how they sort of ran the business, um, as a very efficient business.'

Finally, several interviewees (Eleanor, Grant, Gerard, Felicity and Kay) suggested that knowing how to manage self-employment was also part of understanding the business aspects of General Practice.

How the training environment affected opportunities to gain understanding and experience of business and partnership issues?

The following themes describing the training environment, outlined in Chapter 4, illustrate ways in which the training environment supports the acquisition of knowledge of business and partnership issues:

‘Participation in meetings’ (described in section 4.1.4) and ‘involvement in business management aspects’ (described in section 4.1.5):

These themes suggested that participation in meetings and in business matters reflected the inclusion of trainees in the Practice. The way in which participation in meetings and involvement in business aspects relate to preparedness is further described here:

Being actively ‘involved’ in business meetings or taking responsibility for a particular management area increased confidence and the perception of being prepared. For example Erica (ECGP) explained that she was put in charge of one of the contract areas in her Practice which increased her confidence in dealing with business-related matters. Similarly, Arvind (ECGP) described that an understanding of business aspects gave him confidence in applying for jobs. On the other hand, a lack of knowledge and experience in business and management was a cause for

concern and a deficiency early career doctors noticed when they moved into a new job (this was illustrated in interviews with Eleanor, Sange, Paul, Kevin, Sabil and Raj). The following extract from the interview with Raj (ECGP) illustrates this:

'I was fine with day to day things but was not too sure about the non-clinical things such as insurance and requests for medical reports. I'm still not too comfortable with it as a partner at my new Practice as I'm not too experienced with that. As a partner I don't have any experience with the QOF Targets and the management side of things are harder for me to get used to.'

Although a lack of business experience did not necessarily deter doctors from undertaking partnership jobs on completion of training, as in the cases of Karen, Kevin and Paul, it did result in early career doctors having to learn these new skills in their follow-up employing Practice.

Understanding the operation and dynamics of General Practice partnership contributed to a feeling of being prepared. Such understanding was developed through participation in meetings which enabled trainees to observe how management responsibilities were distributed between the partners and how decisions were made in the Practice. Observing how partners negotiated their differences was deemed a useful learning experience that prepared one for dealing with partnership issues. Geraldine (ECGP) talks about observing friction between the partners in her Practice:

'I actually found it quite helpful because it got me involved in things and I saw the different perspectives. And I wasn't part of the cross-current of that... They were happy for me to sit in on meetings, even with accountants; they were quite open about that as they were happy to help me gain awareness of that side of the Practice. It was good to see how they dealt with issues like that, as they come up with every partnership.'

6.5 Theme 5: Patients and workload

Précis:

Having a concrete notion of their role as GPs in relation to their patients' health was described as an element of being prepared. In addition, understanding the importance of social influences on health and the need to consider these when managing patients was also seen by a number of interviewees as a reflection of preparedness. Preparedness was also defined in terms of the ability of the doctor to manage complex and unexpected cases or clinical situations.

When considering the way in which the training environment impacted on preparedness, many interviewees talked about the importance of dealing with a variety of clinical cases, with medically complex patients, with a diverse and large volume of patients, and with challenging patients and presentations. Success in managing such patients or situations left trainees confident in their own abilities and enhanced the perception of being prepared.

Interviewees also reflected on the different challenges and opportunities associated with training in Practices with predominantly affluent or deprived patient populations. The challenges associated with working with such diverse populations, were deemed preparing and training in Practices with mix population were considered advantageous. Experience of managing diverse patient populations enabled the trainee to more easily adapt to different Practice population at follow up employment.

Finally, interviewees talked about workload in their training Practices. Being able to manage the workload was seen as a reflection of being prepared, while experiencing difficulty in managing workload reduced confidence in the ability to cope with future employment. A heavy workload was considered preparing as it facilitated the development of strategies for dealing with work demands. Nevertheless, heavy workload was also reported to impact negatively on training as it resulted in reduced learning opportunities.

When talking about preparedness, a number of interviewees talked about their role as GPs in relation to their patients' health. For example, Kevin (GPT) explained that he saw his role as providing guidance to patients but that the responsibility for their health remained with them, while Karen (ECGP) viewed her role as being an advocate for those patients who were unable to look after their own interests. For Erica (ECGP) General Practice was about the long-term relationship with patients. Having a clear notion of what General Practice means and of the role of GPs in relation to their patients was viewed as a marker of professional development and as a reflection of preparedness.

The acknowledgement of the significance of social influences on health and of the importance of considering these aspects when managing patients, while accepting the limitations of the doctor's ability to affect patient health, were also aspects which a number of interviewees reflected upon when talking about preparedness. Barbara (GPT) explains how she developed an understanding of the importance of the social aspects of health during her training:

'I was worried about that everything would become social and I would lose track of the medical and I guess I have realised that actually the social is much more important ..and a good GP is someone who can, who understands more of the context and the environment that brought that person to come with whatever problem and I think that if you can understand that a bit better then you can help influence the decision-making about health choices and lifestyle choices, and life choices in general.'

Patients and workload in the training environment and their impact on preparedness

Preparedness was described as confidence in the ability to manage complex, challenging patients and to deal with the 'unexpected'. Being able to 'deal with anything that walks through the door' was a marker of preparedness. When talking about the aspects of their training Practices that were good for preparedness, interviewees, particularly but not exclusively those who worked in deprived areas, reflected on the importance of seeing a variety of clinical and complex medical

cases. Regularly managing complex populations increased confidence in one own ability as a GP, as illustrated by Fatima (ECGP):

'And also a lot of people had multiple co- morbidities so it was quite good to deal with more than just one sort of problem at a time taking everything into consideration... I think regularly dealing with complex problems helped you get experience but also confidence because you were used to dealing with complex problems.'

Experience of working with a diverse and large volume of patients was also considered preparing as it allowed trainees to gain experience in managing different types of patients and varied clinical presentations. Diverse experiences such as providing end of life care, taking responsibility for community hospitals, dealing with road traffic accidents and looking after nursing homes were also suggested as examples of experiences that prepared trainees.

Many interviewees talked about patient populations in their Practices in terms of deprivation or affluence. They reflected on the challenges that either a very deprived population or a very affluent one presented.

Training in deprived areas was challenging due to the medical complexity of many patients, the chaotic way in which they presented and the difficulty of managing risk. Although training in such areas was often exhausting because of the heavy workload, mentally demanding surgeries, lengthy consultations and patients attending very frequently, interviewees suggested that patients were less likely to challenge doctors' decisions. Deprived areas offered excellent learning opportunities as trainees were able to diagnose and treat complex medical conditions, see 'genuine pathology' and develop their consultation skills. The following quote from Andrew (GPT) illustrates this point:

'I think you...you learn to deal with difficult situations or you learn to deal with the fact that patients are pretty chaotic in the way that they present. So they will come in with more than one thing and... can be very inarticulate. And you spend a lot of energy, mental energy trying to order the chaos and that's quite exhausting, but learning to do that gets easier and easier. I think it's quite a useful skill, in a way, that you might not necessarily get at certain other Practices.'

Interviewees suggested that affluent patients were less medically complex and presented in a well organised manner but were more likely to challenge a doctor's knowledge and decisions and to have high expectations. Learning to manage patients' expectations was a desirable skill. Pamela (ECGP) talked about the challenges of dealing with more affluent populations used to being in control of their own health:

'Yea very educated population often in very stressful jobs, often being used to control and not coping well when they didn't have control of their health and probably a bit scared by their ill health. And wanting immediate answers and cures and not liking if you can't deliver that and then trying to put it back on you that it was kind of your fault.'

Working in Practices with mixed populations (deprived and affluent) was suggested to be particularly useful preparation for future employment as Grant (ECGP) explains:

'I know a lot of the colleagues that I had, either worked in very affluent areas or very deprived areas and both have their disadvantages. Whereas I had an excellent mix – seeing everything. And when I then went on to locum, nothing was a surprise. I've locumed in the most affluent areas of (name of city) and the most deprived areas of (name of city) and neither have surprised me because I've seen examples of both in xxx. It was an excellent training Practice in that regard.'

Finally, being able to manage a heavy workload and the multiple responsibilities and tasks associated with General Practice was deemed as a reflection both of 'being prepared' and of an emotional capacity for dealing with the stresses associated with General Practice. Those who trained in small rural Practices, in particularly emphasised the need to gain experience in Practices with heavy workload (e.g. John and Paul). Many interviewees talked about the impact of workload on training. Heavy workload was deemed preparing as it exposed GP trainees to a wide variety of patients and enabled them to develop strategies for dealing with workload and for prioritising tasks.

When trainees found that they could cope with a heavy workload, they felt prepared and confident to deal with similar situations in future employment (e.g. Felicity, Samuel and Grant). However, difficulties in managing workload had a negative effect on confidence. For example Andrew (GPT) explained how his failure to manage the heavy workload in his training Practice in a timely fashion affected his confidence. When he moved to a Practice with less complex population and reduced workload, he was able to manage the workload which in turn increased his confidence. Therefore heavy workload was shown to have a positive or a negative effect on confidence.

A heavy workload, at times, had a negative impact on training, as it reduced learning opportunities. It left little time to look up information during consultations, to be involved in other aspects of General Practice work (e.g. business and audit) and to have joint surgeries with other doctors. It was reported to increase stress and to have a negative impact on work-life balance and potentially even on patient care.

Grant described how the heavy workload which characterised his training Practice affected learning opportunities, had a potential impact on patient care and left little energy for dealing with the management aspects of General Practice:

'Sometimes in xxxx it wasn't "what's the best thing for this patient?" or "how can I make this consultation the best possible consultation with the best possible outcome?" – a lot of it was "how am I going to get them out the door?" so that I can see the next ten that are waiting and work on the five phone calls.'

'The workload did mean that there wasn't that much time for, at the end of the working day, for looking things up or contemplating what to do.. If I had had a bit more time, I perhaps could have read around certain presentations a bit more as I went through them. But I didn't really have time for that, I tended to have to sort things out and move on.'

6.6 Theme 6: Consultation skills and time management

Précis:

Preparedness was described as having good consultation skills. The essence of consultation skills was good communication: extracting information from patients, delineating the problem, managing risk and uncertainties and adapting the style of consultation to patients' needs. Diverse communication strategies were seen as essential and particularly helpful to early career GPs in adapting to different Practice populations when moving into employment. Therefore, the theme 'consultation skills and time management' also relates to the theme 'adaptability'. Being able to manage time effectively, adhering to ten-minute consultations while managing the multiple tasks associated with General Practice work, was also described as a reflection of preparedness. Not being able to manage time well reduced confidence in the ability to cope with General Practice work.

Effective teaching and opportunities for joint consulting with the trainer improved consultation skills, with a corresponding impact on preparedness.

Interviewees described the importance of good consultation skills which relied on good communication skills. Having good communication skills was suggested to result in better identification and addressing of patients' needs and improved time management. For example both Grant (ECGP) and Oliver (GPT) explained that good consultations skills entails being able to take charge of the consultation, efficiently extracting information from the patient, steering and directing the patient into relevant issues in order to clarify the problem and delegating responsibilities or tasks to the patient.

Similarly, Felicity (GPT), Sarah (ECGP) and Samuel (GPT) talked about the importance of having diverse approaches to consultations to suit different patients and their diverse needs. They reflected that having different strategies for dealing with different situations, such as angry or upset patients, increased confidence. Early career GPs suggested that the possession of diverse consultation skills enhanced adaptability to locum work. In addition, a number of interviewees talked about the

importance of 'having a 'Framework' for dealing with uncertainty , and managing risk during consultations which made them feel more confident as Sabil, (ECGP) explains:

'As I said before yes from time to time I will have difficult patients where I wouldn't know what to do but I know how to get on with that sort of patient. I have got a framework in mind and that's what makes me confident that yes I should be ok.'

Being able to consult at 10 minutes intervals throughout a surgery, as the norm in most Practices, was seen as an indication of preparedness by some interviewees. However, the importance of being able to manage time extended beyond consultations, with a number of interviewees (e.g. Geraldine, Paul and Felicity) suggesting that preparedness meant being able to manage the clinical, administrative and managerial tasks associated with General Practice without compromising patient care. The need to operate within a time frame was reinforced by the reality of working as a locum, as work cannot be deferred to the next day.

Not being able to manage time well affected trainee confidence. For example Andrew, who trained in a Practice with a predominantly deprived population, a heavy workload and complex clinical cases, explains that the failure to manage time effectively made him feel unprepared:

'Sometimes, because if you end a consultation and the consultation itself has felt a bit chaotic, and you end up feeling "I'm not sure I've managed all that" or the whole clinic has just, kind of run over and it's all feeling a bit hectic, I think that just dampens your own confidence in that you can manage generally.'

The way in which the training environment shaped consultation skills and time management:

Specific tutorials with trainers which provided practical suggestions, specific techniques for effective consultations and joint consulting with the trainer were all reported to improve consultation skills and time management. These were detailed in the category 'the teaching' (section 5.3).

6.7 Theme 7: Knowledge base and passing RCGP CSA examination

Précis:

Passing the Royal College examination which is a prerequisite for a licence as a GP in the UK was reported to increase confidence. An adequate knowledge base was deemed necessary to support both decision-making and effective consultations.

A number of interviewees talked about passing the examination as a milestone and a sign of being ready for independent practice. Michelle (ECGP), Oliver (GPT) and Becca (GPT) explained that passing the exam increased their confidence and validated their professional status, as the following quote for Michelle illustrates:

'I think passing the exam does give you some confidence you're hopefully meeting the targets the college want you to and sort of help in making you feel a bit more confident practice independently afterwards.'

However, passing the exam was not considered by one and all to be a key marker for being prepared. For example Alex (GPT) explained that his trainer's confidence in him was more important to him than passing the exam. Similarly Grant (ECGP) talked about passing examination as a necessary hurdle. Passing the exam early in the training year allowed him enough time to develop the skills he viewed as essential for a GP, namely, working quickly, efficiently and safely.

Being prepared was also described as having adequate amount of clinical knowledge. Such adequate knowledge base was seen to support other essential skills such as effective consultation and decision making. Keeping up to date was therefore seen as an ongoing necessity as John (ECGP) explains:

'When I understood um...a disease process, managing a patient with that disease process was easy, you get me? So I felt that if I'm going to work every day and come back happy I must study, I must keep abreast, I must understand,

because it makes the day easier than going to a clinic and not understanding about half of what is going on and having to refer.'

6.8 Inclusion and preparedness

The category 'inclusion' described in Chapter 4, has been identified as a facilitator for the perception of being prepared as it related to both 'confidence' and 'adaptability', the two central themes of preparedness. This category was central as it was presented in all interviews.

The importance of being included in the Practice and the elements that contributed to the perception of being included or excluded were discussed in the category 'inclusion'. Feeling a valued member of the team enhanced positive self-value and confidence. The category also describes how participation in informal and formal meetings exposed trainees to a range of views, opinions and approaches to clinical management and to work in general. This enabled trainees to consider different solutions to clinical management and assisted them in legitimising their own professional approach and personal ethos. Seeing that learning was ongoing for all GPs was reassuring and increased trainee confidence. In addition, being made aware of various approaches to clinical management enhanced adaptability to future work.

As explained in sections 4.1.4 & 4.1.5, taking part in meetings and in professional conversations enabled trainees to get a sense of the ethos of the Practice and its doctors. This allowed trainees to reflect and develop their own professional values. Similarly inclusion in formal business meetings made trainees aware of non-clinical aspects of General Practice such as partnership dynamics, negotiation of conflicts and decision-making relating to staff management. Being actively involved in business management by undertaking particular responsibilities, was a reflection of inclusion but also enhanced trainee's confidence in managing these aspects in future. Participation in the broad aspects of General Practice work, clinical and non-clinical, was a reflection of inclusion and was deemed preparing.

Chapter 4 has already illustrated that the Practice ethos was determinant to the inclusion of the trainee. It illustrated that Practices characterised by less hierarchical relationships were also more 'progressive', tended to enjoy better team work among the doctors and were more inclusive of trainees. They were good at supporting trainees in dealing with significant events or errors, thus building their confidence in dealing with such issues in the future. In addition, inclusive Practices allowed trainees to lead on identifying and addressing their learning needs, which facilitated self-direction and hence confidence. There were also greater opportunities in such Practices for trainees to take an active role in the broader aspects of General Practice work and therefore develop professionally.

A good example to illustrate the above is an extract from the interview with Kay (GPT) who felt well integrated into her training Practice which was characterised by progressive thinking, good team work and less hierarchical relationships among the GPs. She explains how being included and therefore involved in all aspects of General Practice work, made her feel better equipped to apply for a partnership position on completion of her training:

*'I think that I have just kind of learned about General Practice as a whole from them, it has not just been an isolated experience where I see the patients, I do the visits and go home, I have been **really** involved in **everything** that has gone on there and so, when I started the year I never thought that I would apply for a partnership at the end of it, but I think that is probably a reflection of what they have taught me over the year that I feel ready for that because [thinks] I feel like I have been exposed to it all, I know the pros and the cons I know how hard it is and how hard they work, but I feel prepared by that.'*

Table 10 provides further quotes to illustrate how inclusion facilitates the perception of being prepared.

Table 10: Perception of inclusion and preparedness

Interviewee	Perception of inclusion	Preparedness
Barbara	Did not feel included	Lack of support in dealing with significant events, reduced confidence in dealing with such events in future: <i>I think Christ am I ever going to be able to say anything to a patient without wondering and worrying that they are going to out a complaint ?</i>
Eleanor	Did not feel included	Reduced confidence to apply for partnership: <i>There were a few people who went straight into partnerships from registrar and I have no idea how they would have done that. I would have never felt equipped to make that sort of decision. I think partly it was because there was very little involvement of the registrar in the partnership side of things.</i>
Samuel	Did not feel included	Reduced self-value (confidence): <i>Um, so I think I felt as a trainee quite sort of undervalued in terms of how much I could contribute to the running of the Practice, because it just ran that way and, you know, they didn't seem that interested in new ideas or suggestions.</i> Reduced opportunities to be involved in service improvement: <i>I tend to want to be in charge of my learning and my sort of working environment, and, um, I'm not very good at simply doing what I'm told without questioning it, if I see a way things could be done better, I always want to put that forward and, you know, I like to see if progress can be made, or at least a compromise can be reached. Um, so I think I felt as a trainee quite sort of undervalued.</i> In contrast, his second training Practice which was inclusive encouraged trainee's involvement, increasing confidence in management aspects: <i>Whereas in this Practice it's been very useful being involved in discussions about, um, service development, discussions about the financial side of things, about staff management. I feel also from this Practice much more prepared in terms of the running of the Practice, how to go about relating to staff and managing problems with staff, the sort of management of the more financial side of the Practice.</i> Considering different approaches made him more adaptable: <i>It gives me an idea that there are different ways to do things and I think that gives me a greater flexibility in terms of thinking about ways I would do things in the future.</i>
Raj	Did not feel included	Lack of preparedness for management aspects: <i>The side that you don't get as prepared for is the management and admin side of things like forms and reports. The admin and management side of things.</i>
Geraldine	Felt Included	Awareness of various legitimate approaches for clinical management (supporting adaptability and confidence): <i>I actually found it (involvement in meetings) quite helpful because it got me involved in things and I saw the different perspectives.</i> <i>Other GPs would sometimes say that they would have done something different in regard to patient care or treatment.</i>
Emily	Felt included	Awareness of various legitimate approaches for clinical management (supporting adaptability and confidence): <i>Also, as a trainee, you get to know what the people, or advice that different people will give you, and you know that different people have different approaches.</i>

Interviewee	Perception of inclusion	Preparedness
Erica	Felt included	Increasing confidence in management aspects: <i>I went to all the business meetings and in this Practice they've put me in charge of one of the contract areas which is quite handy as well. I think the more you take on in your registrar year the more you will be prepared for independent practice.</i>
Sabil	Felt included	Support for trainee in dealing with significant events enhanced confidence: <i>When I made that mistake on that patient the trainer he encouraged me to make my own decision and he just supported those decisions so again I would say yes it was very nice of them I never felt let down at any stage.</i>
Pamela	Felt included	Leading in identifying and addressing learning needs (supporting self direction and therefore confidence): <i>I would say that the overriding thing was they were there to support me learning for myself.</i> Respect for trainee professional approach enhanced confidence: <i>Yea, and being encouraged to respect my own decision making, which I think was a big thing for me.</i>

Nevertheless, although being included contributed to the notion of being prepared it was not the sole determinant. For example Karen (ECGP), who did not feel included and had few opportunities to be involved informally or formally in her training Practice, still felt confident enough on completion of her training to apply for a partnership position. This suggests that the perception of being prepared is also determined by factors personal to the trainee.

There was also an indication that the extent of trainee's involvement also depended on their personality and the degree of initiation they took. Some trainees felt that it was sufficient for them to be included in the clinical team but not necessarily in the management team (Grant and Alex) while others were motivated to be included in various aspects of the Practice (Arvind, Kay and Geraldine).

6.9 Key Issues: the meanings of preparedness and the ways the training environment impacts on preparedness

The following is a summary of the meanings GP trainees and early career GPs attributed to 'preparedness'. The relations between the themes were illustrated in Chart 2 (p.188) which showed that the meaning of preparedness centred around two main themes: 'confidence' and 'adaptability', the two central elements of preparedness.

The following meanings were attributed to preparedness:

- A sense of confidence in one's own skills and decision-making.
- The ability to adapt and to work in different environments on completion of training.
- The ability to work 'on your own' and to be 'self-directed', that is, to seek solutions, make decisions and take responsibility for patient care as well as for one's own continuous professional development.
- An understanding of business aspects of General Practice including finance, staff management and partnership dynamics.
- A clear notion of the role of a GP in relation to patients and an understanding of social determinants of health.
- The ability to manage complex, unexpected clinical cases or clinical situations and diverse patient populations.
- The ability to manage workload and time.
- The possession of good consultation skills with diverse communication strategies.

- Passing the RCGP examination and having a knowledge base adequate to support communication skills and decision-making.

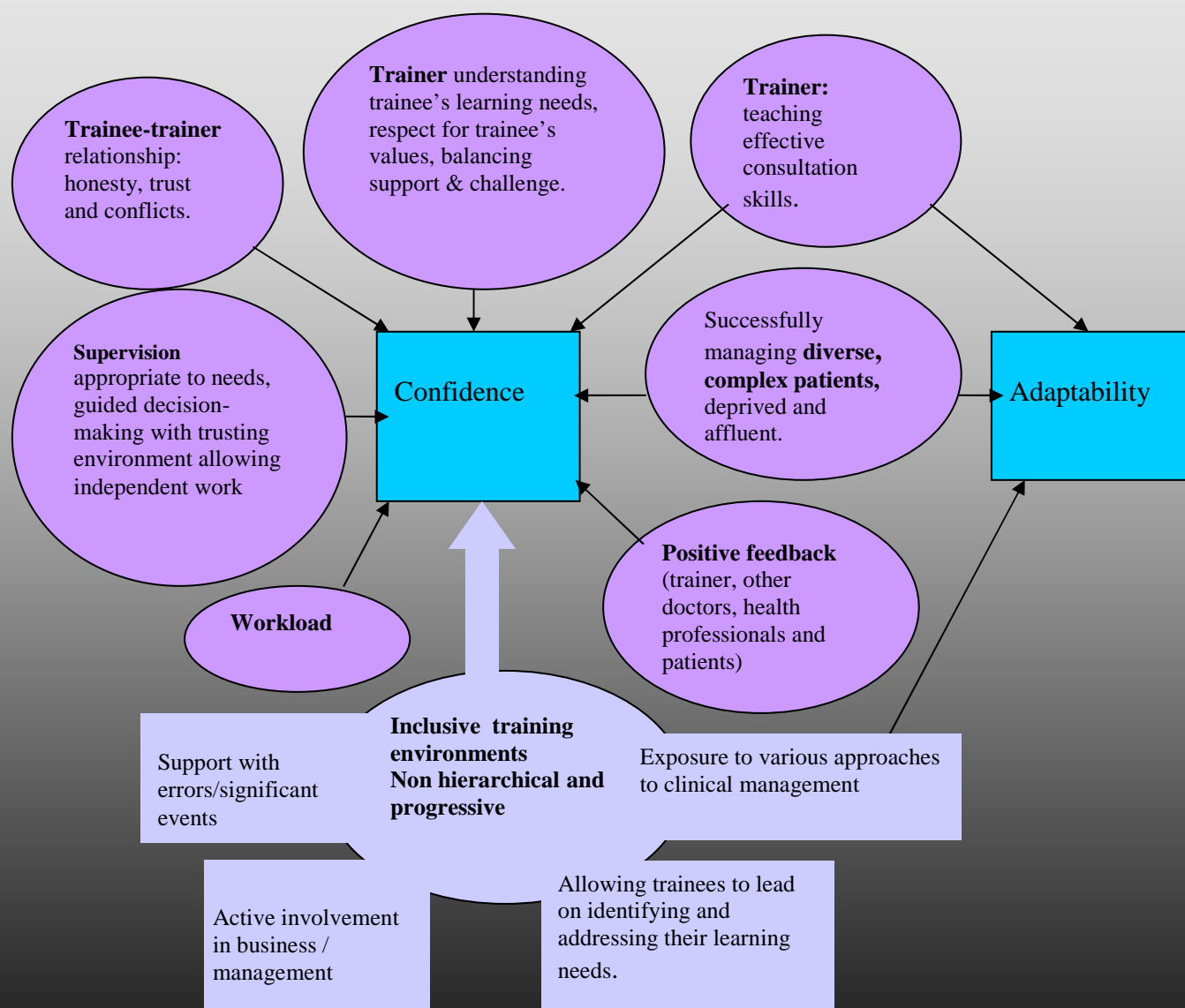
The ways in which it was suggested that the training environment impacted on confidence and adaptability, the two central themes of preparedness, are summarised below and illustrated in Chart 3 (p.219):

- Practices characterised by less hierarchical relationships among GPs and by good team work were progressive and inclusive of trainees. Inclusion supported perceptions of both confidence and adaptability.
- The trainer's belief in the trainee's abilities and encouraging feedback from the trainer as well as from other doctors, health professionals and patients all enhanced the confidence of trainees in their own abilities.
- Trusting trainees to work independently, while supporting them through appropriate levels of supervision and guided decision-making and allowing them to lead on identifying and addressing their learning needs, increased confidence and supported 'self-direction' (the ability to work on your own).
- Being actively involved in business or non-clinical matters, whether by being included in meetings and discussions or by undertaking a management responsibility, enhanced the perception of being prepared and increased confidence in the ability to manage the business side of General Practice work.
- Opportunities to manage medically complex patients, a variety of diverse clinical cases and challenging patients and presentations increased confidence and adaptability
- A heavy workload was good preparation as it encouraged trainees to develop

strategies for managing work, although it had the potential to impact negatively on learning opportunities. It was reported to impact either positively or negatively on confidence.

- Providing trainees with practical solutions during teaching sessions assisted them in improving and developing diverse consultation skills, which in turn increased their confidence and enabled them to adapt easily to future employment.
- Having the opportunity to train in more than one Practice enabled trainees to see different approaches to clinical and business management and had the potential to facilitate the development of a more flexible approach to problem-solving. It also at times, provided opportunities for trainees to work with different patient populations.
- The trainer's guidance of trainee in identifying and addressing their learning needs, adaptation of support or feedback to needs and respect for the trainee's own professional approach assisted in building confidence.
- Appropriate balance between support and challenge during teaching and adjustment of feedback to the needs of the trainee increased confidence. Teaching of effective consultation skills enhanced adaptability.
- Trainee-trainer relationships at time affected trainees' confidence, particularly when such relationships were characterised by conflict.
- It was surprising that the findings were not affected by the different dimensions of the trainees. So for example 'inclusion' was important both for trainees who trained in large and small practices, rural and urban practices, UK medical graduates as well as non-UK medical graduates and female and male trainees. This implies that the finding in relation to inclusion is generic and not specific to a type of General Practice or trainee.

Chart 3: The training environment in General Practice and its impact on confidence and adaptability.



Chapter 7: Discussion

This study was set out to answer three research questions:

1. How do GP trainees and early career GPs describe their training environment in General Practice?
2. What meanings GP trainees and early career GPs attach to preparedness for practice?
3. In what way do GP trainees and early career GPs perceive their training environment to impact on their preparedness?

This Chapter synthesises the research findings and explains how they answer the above questions. The findings are also related to relevant published-literature on workplace learning and preparedness.

7.1 Summary of main findings

GP trainees and early career GPs described their training Practices in terms of the following:

- Their sense of inclusion in the Practice.
- The Practice ethos and their relationship to it.
- The importance of training within the Practice.
- The GP trainer's personal qualities, relationship with the trainee and the teaching.

There was no unanimous way in which GP trainees and early career GPs described preparedness, however, the meanings attributed to preparedness centred around the two main themes of 'confidence' and 'adaptability', and included:

- Working independently and being self-directed.
- Knowledge of business and partnership issues of General Practice.
- Ability to manage patients and workload.
- The possession of good consultation skills and effective time management.
- Having adequate knowledge and passing the RCGP CSA examination

Being able to manage varied, complex patients and workload as well as the possession of good consultation skills and an adequate knowledge base, assisted GP trainees in adapting to future work and made them more confident in their abilities. Working independently, being self-directed and gaining understanding of the business and partnership aspects of General Practice also enhanced confidence.

The third question, *‘in what way do GP trainees and early career GPs perceive their training environment to impact on their preparedness’* was more complex to answer and requires a multi-layered response. When describing the training environment in General Practice, interviewees spoke of the way particular aspects of the training environment impacted on preparedness. These are listed below:

- Practices characterised by less hierarchical relationships between the doctors and by a ‘progressive’ nature, tended to have good team work. Such Practices were seen as particularly inclusive, more readily adapted to trainees’ learning needs, were caring supportive and approachable to trainees. ‘Inclusion’ enhanced both ‘confidence’ and ‘adaptability’, the two central elements of preparedness, in the following ways:
 - It encouraged positive self-value.
 - Inclusive Practices, by providing care and support in dealing with clinical errors and other significant events, developed confidence in dealing with such situations.

- Inclusive Practices more readily allowed active participation in business management, increasing confidence accordingly.
- Inclusion in professional conversations provided acknowledgement of a variety of legitimate approaches to clinical management, thus increasing confidence in the trainee's own approach and decision-making. This facilitated the development of professional judgements and values. Awareness of various approaches to clinical management also assisted adaptability to future work. Involvement in professional conversations and observation of doctors exchanging ideas showed that learning was ongoing and integral to continuous professional development. It also allowed trainees to develop an understanding of non-clinical aspects of General Practice (staff management, partnership dynamics and business aspects) thus increasing confidence in dealing with these matters.
- Inclusive Practices, by enabling trainees to lead on identifying and addressing learning needs, facilitated self-direction and, consequently, confidence.
- Practices that offered a level of supervision which was appropriate to trainees' needs, trusted trainees to work independently and guided them in their decision-making, thereby enhancing the confidence to work on their own.
- The trainer was important in building trainees' confidence in their own abilities by:
 - Assisting trainees in identifying and addressing their learning needs during teaching sessions and respecting their professional approaches or attitudes.
 - Providing encouraging feedback on performance, adjusted to the needs of trainees, and by balancing support and challenge during tutorials.

-Providing effective teaching in the form of practical solutions, joint consulting and guidance to improve and develop diverse and effective consultation skills. This also enhanced adaptability to future work.

- A difficult relationship or conflicts with the trainer, often stemming from a conflicting ethos, had a negative effect on trainees by reducing support and by restricting professional development. A difficult relationship also impacted negatively on confidence. Conflicts resulted in the trainees feeling less included in the Practice thereby having an additional indirect effect on preparedness.

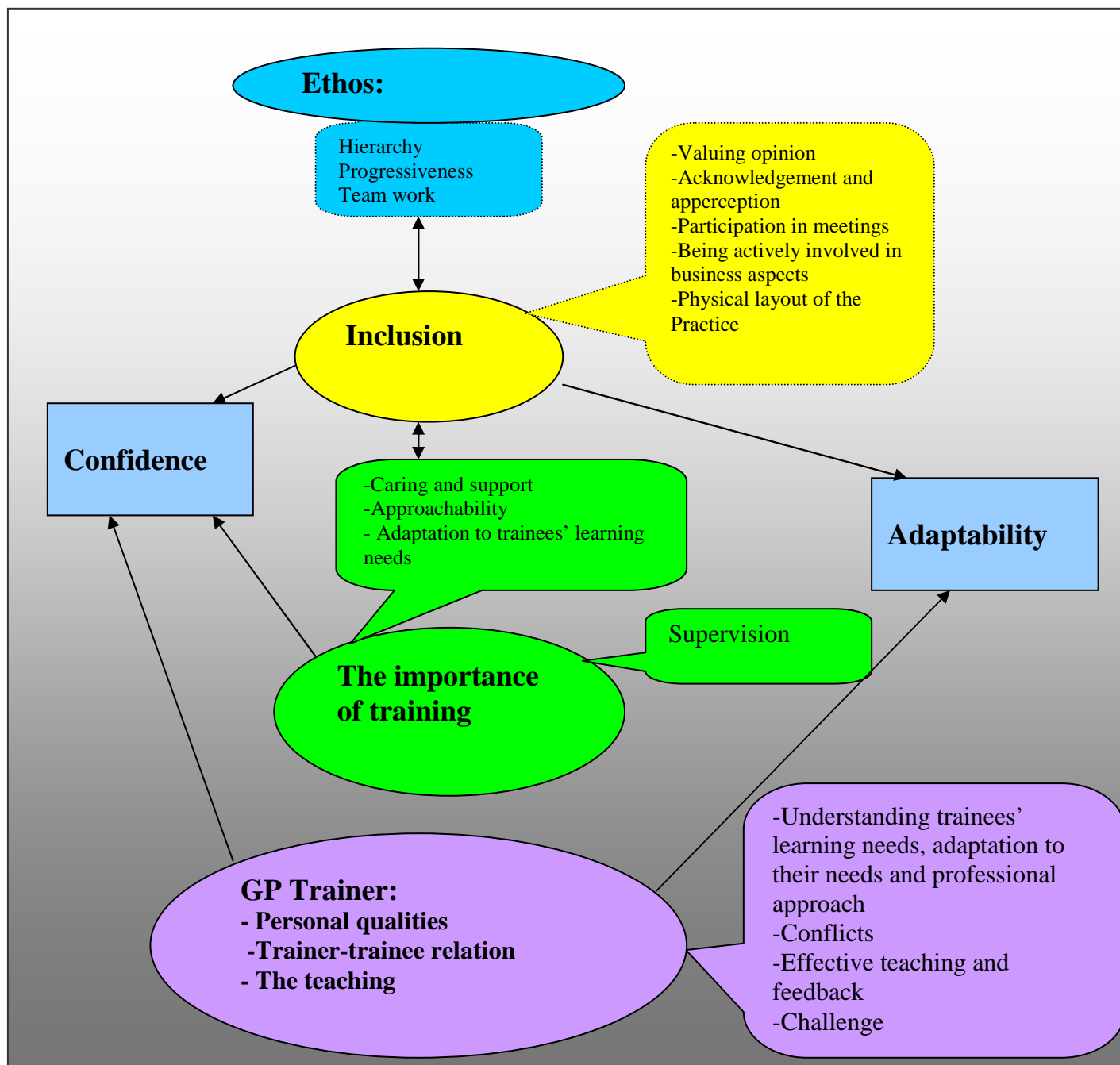
Other issues with an impact on preparedness which were not raised when interviewees described their training Practices but rather when they talked about preparedness itself included:

- Positive, encouraging feedback from other doctors, health professionals and patients increased confidence.
- Opportunities to manage complex patients, diverse clinical cases, challenging patients and presentations, increased confidence and adaptability.
- A heavy workload impacted positively on confidence when trainees coped successfully through the development of effective strategies. Failure produced a negative impact and reduced opportunities to participate in other aspects of General Practice work.
- The opportunity to train in more than one Practice enhanced adaptability.

Chart 4 (p.224) provides a pictorial presentation of categories and themes describing training Practices - as outlined in Chapters 4 & 5 - shown to impact on the two central themes of preparedness, namely, confidence and adaptability. The circles represent the categories, the callouts the themes relating to the categories, the squares the two central elements of preparedness: confidence and adaptability. The arrows indicate 'relatedness' between categories and themes. The Chart illustrates that

themes from the categories 'Practice ethos' and 'the importance of teaching within the Practice' relate to the category 'inclusion'. The category 'inclusion' (with its related themes) together with the category 'the GP trainer' and the theme 'supervision', all impacted on the two central themes of preparedness.

Chart 4: Categories and themes describing the training environment, which impacted on preparedness.



These findings are next discussed in the context of the published literature. First the way the training environment in General Practice was described is considered. Then the two central elements of preparedness, namely, confidence and adaptability, and the findings on the way the training environment impacted on these elements are discussed in view of existing theories and published research. Finally, the main aspects of the GP training environment that were shown to impact on preparedness, namely, inclusion, supervision and the trainer, are considered in view of the literature and relevant theoretical lenses. Aspects of the training environment that were not shown to affect preparedness are also summarised.

7.2 The training environment in General Practice

Interviewees described their training General Practices in terms of their inclusive nature, the ethos of the Practice and whether this ethos was congruent with their own ethos, and the importance attached to training. They also talked about their GP trainer whose role will be specifically discussed in section 7.3.5.

The inclusive nature of the Practice was reflected in the extent to which trainees felt part of the team, were able to undertake additional responsibilities and were acknowledged and appreciated for doing so, and whether they participated and were actively involved in formal and informal meetings, including professional conversations. Practice ethos was described in terms of the existence of hierarchy among doctors and between the doctors and Practice staff, the progressive nature of the Practice, the extent to which the doctors worked as a team, the Practice-patient relationships and the relationships between the doctors themselves.

Interviewees reflected on whether their own ethos was in or out of line with that of the Practice. The importance of training within the Practice was demonstrated by flexibility in adapting to trainees' learning needs, including supervision, the approachability of all staff, the pastoral care and support offered to trainees particularly in dealing with significant events and the availability of more than one trainer. Feelings of exploitation were also a marker.

There are demonstrably consistent relationships between some of the themes used to describe training Practices. These are illustrated in Chart 4 (p.224) and in Chart 1 (p.96). In summary:

Practices described as less hierarchical, particularly vis-a-vis trainees, were also more progressive (open to new ideas and more amenable to change), with the doctors working as a team. When it came to trainees, such Practices were inclusive, approachable, supportive and caring, and readily adapted to learning needs. Trainees felt part of the team and did not feel they were exploited. For the purpose of this discussion, such Practices will be referred to as '*inclusive training Practices*'.

Other themes describing the training Practice such as 'Practice-patient relationships', 'relationships between the doctors', 'organisation of work' and 'having more than one trainer' were not interrelated as I was unable to illustrate consistent relationships between these aspects in this study. Thus for example poor organisation of work occurred both in 'inclusive', non hierarchical Practices and in 'non inclusive' hierarchical practices.

It was clear that, in describing 'ethos', interviewees reflected on whether that of the Practice fitted with their own. Such perceptions were shaped by what trainees saw while working in their training Practice. This suggests that much of the learning about the values and attitudes ingrained in General Practices is tacit and occurs informally. This supports previous findings which proposed that learning in medicine is often tacit (Epstein 1999; Cruess, Cruess and Steiner 2008). The findings suggest that tacit learning shapes trainees' views and expectations of future employment and of the type of Practice they wish to join. Interviewees often expressed a desire to work in a Practice that shares their ethos. This finding echoes Billett and Smith (2006) who suggested that learners develop their own professional identity through interaction with social practices and norms and that consequently they desire to work in places that reflect that same identity.

7.3 Preparedness

Medical education literature has defined preparedness in a number of ways such as self-confidence in using particular procedures or skills, self-assessment of competence in clinical and generic skills, or the views of others on whether a doctor is prepared. Transition has also been suggested as an alternative concept to preparedness. The relevant literature was reviewed in Chapter 2. Previous studies on the preparedness of GP trainees identified particular knowledge or experience deficits which were still present on completion of training programmes (McKinstry, Dodd, and Baldwin 2001; Sibbett 2003; O'Shea 2009; Bedward *et al.* 2011). This study was not set to investigate whether GP trainees and early career GPs felt prepared and it did not use existing definitions of preparedness. Rather, it sought to examine the meaning that GP trainees and early career GP themselves attribute to preparedness.

The findings suggest that the meaning GP trainees and early career GPs attribute to preparedness centred around two main categories of 'confidence' and 'adaptability.' Confidence was not specific to particular skills, procedures, or clinical areas as so often defined by previous studies, as learning in relation to these areas was considered ongoing. Rather it related to an inner confidence in the skills and decision-making needed for the management of patients. The ability to be self directed was considered to be more important. Self-belief in the ability to work independently, to seek solutions and make decisions, to undertake responsibility for patients, to manage workload and complex patients within their social context, and the belief that one is in the possession of adequate consultation skills and medical knowledge, all contributed to the feeling of confidence. Understanding business and partnership aspects of General Practice also enhanced confidence in the ability to manage non-clinical work.

The ability to adapt easily to future work in different contexts was also described as an important element of being prepared. Managing a variety of complex patients and workloads, having good consultation skills and an adequate knowledge base

enhanced adaptability. The findings suggest that, although confidence is paramount for preparedness, it needs to be supported by the ability to adapt to different working environments.

7.3.1 Confidence and the way the General Practice training environment impacts on confidence.

The notion of confidence, which was identified as a central element of preparedness, can be explained through Bandura's theory on self efficacy. Bandura's social cognitive theory argues that the concept of confidence should be replaced with the term 'self-efficacy' defined as '*beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments*' (Bandura 1997 p.3). Four broad categories of occurrence contribute or enhance self efficacy:

- Enactive mastery (success in attaining goals)
- Vicarious modelling (seeing others succeeding and modelling such behaviour)
- Verbal persuasion (from others)
- Arousal (response to physiological factors such as stress).

The findings on the way the training Practice can impact on preparedness as described in Chart 2 (p.188) can now be interpreted through Bandura's theory. GP trainees who successfully managed complex varied patients and heavy workload, were supported and dealt with significant events, and were actively involved in business aspects reported to be more confident in their abilities. In the context of Bandura's theory, such activities can be viewed as 'goals' and successful attainment of them can be seen as 'enactive mastery'. Joint consultations with trainers, exposure to diverse approaches to clinical management of patients through participation in professional conversations, and participation in business meetings allow for 'vicarious modelling'. Encouraging, positive feedback on performance from trainer and other doctors, health professionals or patients constitutes 'verbal persuasion'.

‘Inclusive’ training Practices created better opportunities for ‘enactive mastery’. They included trainees regularly in professional conversations, which in turn supported their decision-making in the management of complex patients. They also afforded greater opportunities for trainees to be actively involved in business aspects of General Practice. In addition, they supported trainees in dealing with significant events and clinical errors, thus increasing their confidence in dealing with such events. In ‘inclusive’ Practices there were also greater opportunities for ‘vicarious modelling’ and ‘verbal persuasion’ through participation in meetings, professional conversations and joint consulting.

The literature suggests that a number of environmental factors can affect self efficacy. For example, the belief that one has personal control over job situations is suggested to promote self efficacy (Bandura and Wood 1989; Gist and Mitchell 1992). The findings from this study support that proposition by showing that less hierarchical and more inclusive Practices allowed trainees to have greater control over their work in order to address their learning needs, thereby encouraging self-direction and contributing to feelings of self-efficacy and empowerment. Delva et al (2004) and Kirby and Knapper et al (2003) also showed that independence and control over work were characteristics of those training environments which promoted learning of doctors.

In addition, the literature suggests that work situations which advance problem-solving also promote self-efficacy (Cunningham *et al.* 2002). The findings from this study support that view in as much as opportunities to manage varied, diverse and medically complex patients increased both confidence and adaptability through the development of problem-solving skills. Thus Practices where GP trainees encountered complex, varied and diverse patients provided such opportunities. This is in agreement with others who also showed that direct clinical encounters with patients facilitated doctor’s learning (Gibbins, McCoubrie, and Forbes 2011; Billings, Curtis, and Engelberg 2009; Brennan *et al.* 2010; Illing *et al.* 2008; Illing *et al.* 2013; Pearson and Lucas 2011a,b).

The present findings indicate that being trusted to work independently, while being supported and guided in decision-making, increased confidence. The role of guided decision-making can be interpreted through the lens of Vygotsky's theory which claims that an essential element of learning is the creation of 'zone of proximal development' (Vygotsky 1978). This zone refers to what a learner can learn with the support from a 'more knowledgeable other'. Shared problem-solving between novices and more experienced 'others' is essential for learning, according to this theory, and enables the novice to develop skills, strategies and higher mental functions. Guided decision-making from a more experienced GP, can be seen to provide a 'zone of proximal development', which supports trainees' decision-making skills and consequently enhances their confidence in managing patients.

The present study suggests that confidence was also derived from a sense of self-awareness, by which is meant an awareness of knowledge limitations and boundaries and of when and where to seek advice. The importance of self-awareness was highlighted by Rhind et al (2011) who identified recognition of limitations and of the need to seek advice as important attributes in easing the transition of veterinary students into independent practice.

The findings, however, indicate that, although the feeling of confidence on completion of training can be affected by the training Practice environment, it may also be derived from a confidence inherent to individuals. Both Paul and Karen, for example, secured long-term employment on completion of their training despite having a difficult training experience which sapped their confidence. Possibly they had personal qualities which pulled them through the training and made them feel confident despite the difficult training environment. Conversely, completing their training and passing all their assessments, despite the ongoing difficulties, may have produced a feeling of achievement which enhanced confidence and a sense of 'enactive mastery'. There might be however various reasons as to why doctors choose to secure or defer opportunities for long-term employment.

An adequate knowledge base and a pass in the RCGP CSA examination increased confidence. I was however unable to illustrate whether in that regard the characteristics of the training Practice had an impact, although passing the examination may have served as ‘enactive mastery’ and consequently enhanced confidence.

Finally, confidence or self-efficacy is not significant only early on in a General Practitioner’s career. The importance of self-efficacy in the maintenance of motivation, performance, self-regulation and leadership skills has been highlighted in psychological research (Chong and Ma 2010; Harrison *et al.* 1997). Self efficacy supported by the ability to be ‘self directed’ can therefore further enhance the motivation and performance of doctors in future. This suggests that the development of self-efficacy is a positive and an important outcome of GP training. and that it important that GP trainees train in environments that support its development.

7.3.2. Adaptability and the way the training Practice impacts on adaptability

Adaptability was the second central element of preparedness, a finding which supports Fraser and Greenhalgh's (2001) argument that doctors should be educated for capability rather than competence, that is the ability to adapt to change, augment knowledge and improve performance.

Adaptability was enhanced by having diverse consultation skills, good knowledge base and decisions-making processes and through experience of working with a varied patient population (e.g. affluent and deprived). Exposure to a range of legitimate approaches to clinical management also supported adaptability.

The importance of communication skills is reflected in the RCGP CSA examination which assesses them. However, this study suggests that interviewees, particularly early career GPs, saw such skills not just as an examination necessity but as an essential requirement for work in General Practice. Other medical professions

highlight the same point. For example Rhind *et al.* (2011) identified good communication skills with clients as an important factor in assisting the transition of veterinary students into independent practice on completion of training.

Teaching of communication skills to address the needs of diverse populations was, therefore, important in preparing trainees for future work. Confidence in the use of these skills, particularly challenging communication skills, has been reported in a number of studies as a sign of being prepared (Illing *et al.* 2008; Illing *et al.* 2013; Goldacre, Taylor, and Lambert 2010; Matheson and Matheson 2009). The role of trainers was critical in the development of trainees' consultation skills. Teaching was particularly effective when trainers provided practical solutions and specific techniques to improve and develop diverse consultations skill. Joint consulting with trainers was a helpful teaching tool which was commonly used in 'inclusive training Practices'. The usefulness of joint consulting was also identified by Pelgrim *et al.* (2012) who suggested that reciprocal relationships between GP trainees and trainers allowed GP trainees to observe their trainers and give them feedback on their own performance. This enhanced learning from feedback that GP trainers than gave trainees on WPBA.

Interviewees suggested that the experience of working with and managing diverse patient populations enhanced adaptability. The opportunity to train in more than one Practice helped too as it allowed GP trainees to experience different managerial approaches in General Practice, alternative approaches to clinical care and different patient populations. This allowed trainees to develop flexible approaches to problem-solving and work in general. Others have also reported trainees in extended General Practice schemes to benefit from the opportunity to work in a different Practices (Field, Mathers and Lane 2002; McKinstry, Dodd, and Baldwin 2001). The present study, however, suggests that training in an additional General Practice not only broaden trainee experience, it also enhances adaptability.

Finally, awareness of a range of acceptable approaches to clinical practice enabled trainees to develop flexible approaches to problem-solving. That process was

facilitated not only through training in a second Practice but also through inclusion in professional conversations, where various approaches were considered. Inclusion of the trainee in the Practice afforded such opportunities with a positive effect on adaptability. This aspect will be discussed in more detail in the following section.

7.3.3 Inclusion and community of practice- their relation to confidence and adaptability

A characteristic of the training environment with a significant impact on preparedness was its inclusive nature, that is, the extent to which a trainee felt included in and ‘part of’ the training Practice. The Lave and Wenger (1991) ‘situated learning theory’ assists in understanding the importance of ‘inclusion’. That theory, developed through ethnographic studies of traditional ‘apprenticeships’, describes learning as a social process which evolves through collaboration with other learners and more senior community members. Learners learn by doing and participation in the community enables them to learn skills, rules and procedures shared by that community. Through discussion, community members create ‘shared meanings’, share ideas and resources which support their actions and contribute to the development of professional identity (Wenger 1998). Shared experiences enhance the sense of belonging to the community. Figure 2 provides a pictorial representation on the way in which learning occurs through participation in a Community of Practice

Figure 2: Community of Practice (illustration taken from Ed Tech &D06)



This study suggests that the inclusion of trainees facilitated participation in the ‘Community of Practice’ which General Practice presents. Inclusion provided opportunities for trainees to engage with other GPs and to learn new skills (for example, through participation in business management), facilitated the development of decision-making skills, professional judgements and values through participation in professional conversations, and enabled trainees to observe different approaches to clinical management and work in general. Being included in meetings and having their opinions heard and taken on board contributed to the development of confidence and self-value. Trainees who felt part of their training Practices were also better supported in dealing with significant events or clinical errors which in turn enhanced their confidence in dealing with such situations in the future. As highlighted in sections 7.3.1 and 7.3.2, inclusion proved important in supporting the two central themes of preparedness - confidence and adaptability.

In inclusive training Practices, all the doctors were accessible to trainees, providing support and advice during surgeries. Inclusive Practices, were also non-hierarchical, progressive and open to new ideas, and therefore can be viewed as ‘expansive’ training environments as defined by Fuller and Unwin (Fuller and Unwin 2003; Fuller and Unwin 2010). Trainees had opportunities to take part in the ‘community

of practice', to take responsibility and to participate in all aspects of clinical and non-clinical work. They were encouraged to identify and address learning needs and allowed to control or have an input into rota design. This approach empowered and facilitated self-direction. On the other hand, Practices characterised by hierarchical relationships, which were not progressive or open to new ideas, were not as inclusive and so restricted trainees' participation in their 'community of practice', leaving them feeling less prepared for future work. Such Practices also discouraged trainees from leading on identifying and addressing their learning needs.

The finding that less hierarchal and progressive Practices, were also more inclusive of trainees is a significant one. O'Brien and Teherani (2011) argued that progressive training environments which are open to change invite trainees to join in that process. In such environments, trainees can influence and even lead on changes with the potential to improve patient care. The inclusive nature of training General Practices is therefore vital in providing trainees with opportunities to develop leadership skills. Such skills are not only requisites of the GP curriculum but are also important for the future commissioning and managerial roles of GPs, as outlined in recent government proposals (Department of health 2010).

Pearson and Lucas (2011b), in a case study of a teaching General Practice, suggested that lack of hierarchy helped to build respect for learning in a teaching Practice which contributed to the personal 'engagement' of the learner with learning. Thus, although their study did not examine preparedness as such, they pointed out that hierarchical relationships can impact on learning.

In addition, Pearson and Lucas concluded that an ethos of teaching Practice which supports learning is a drive to continuously improve and a passion and commitment for teaching and learning. Recognition of the learner and provision of individual support reflect such an ethos. The current study further highlights the importance of a progressive ethos and a lack of hierarchy in a training Practice. The findings illustrate that non-hierarchical Practices were more progressive and inclusive, with a culture of learning from mistakes and of embracing change. They adapted more

easily to and allowed trainees to lead on and address learning needs. Inclusion also supported the two central elements of preparedness, confidence and adaptability. This current study therefore adds that a progressive, non-hierarchical training Practice is not only important for learning but also for preparedness.

The present findings do not, however, coincide with the conclusions drawn by Cornford and Carrington (2006) from studies of GP trainees early on in their placements. They argued that trainees could not be fully included in the 'community of practice' because they did not truly share its goals. The main goal of the trainee is to learn. GPs have different goals such as service delivery or income. As against that, this study indicates that trainees can participate in a 'community of practice' if the opportunities are afforded by inclusive, supportive training Practices. Inclusion enabled trainees to learn about the goals of the 'community' and to take on additional responsibilities in support of its work. The apparent inconsistency between the findings of the two studies may be explained by the differences in the stage of training of participants. With Cornford and Carrington, trainees were early on in their placements. In this study, trainees were interviewed at the end of or retrospectively on completion of their training.

There is however some evidence in this current study, that the process of inclusion evolves over time, a reflection of what Lave and Wenger described as the move of a 'newcomer' from peripheral to full participation in a community of practice.

By assuming clinical responsibilities, the trainee attained 'legitimate participation' in the community. Trainees who were involved and included not only undertook the routine roles and responsibilities of a GP but also learned about them through taking part. Trainees who felt included did not see themselves as exploited when undertaking additional responsibilities. Of particular importance were opportunities to be involved in the business and managerial aspects of General Practice through participation in formal meetings or informal discussions. Active participation by undertaking managerial responsibility or leading on initiatives particularly enhanced confidence. Inclusive environments provided greater opportunities for trainees to take part in managerial or business activities and to lead on initiatives.

That important conclusion contrasts with other reports to the effect that newly appointed consultants or attending physicians, often feel less than prepared for managerial, financial and administrative tasks (Westerman *et al.* 2010; McKinstry *et al.* 2005). This study suggests that the training environment shapes opportunities and that, when it is inclusive, it is particularly conducive to learning about business management. The finding that opportunities varied between Practices and were affected by their inclusive nature echoes Billett's (2011) distinction between the 'intended curriculum' (leadership and management skills as outlined under the primary care management and community orientation competencies area of the RCGP curriculum) and the 'enacted curriculum' (opportunities and experiences available in the workplace).

The significance of inclusion and of its effect on perceptions of preparedness is supported by other researchers who suggest that involvement in medical teams motivates, facilitates learning through greater opportunities for clinical encounters and increases the confidence of students and junior doctors. (van der Zwet *et al.* 2011; Pearson and Lucas 2011a,b; Dornan *et al.* 2007; Lempp, Cochrane, and Rees 2005; Roberts *et al.* 2012 ; Boor et al 2008, Cornford and Carrington 2006). However the findings from this study suggest that inclusion provides not only opportunities to learn clinical skills through engagement with patients. In the context of postgraduate medical education, inclusion enables trainees to develop non-clinical skills (such as finance, staff management), fosters confidence, and creates space for the development of professional values and judgement.

Similarly, in a study of more senior doctors in training, Stok-Koch, Bolhuis, and Koopmans (2007) reported that the most influential factor in workplace learning, as cited by trainee nursing home physicians, was a sense of belonging and a feeling of integration. Studies of learners in other professions also highlighted the benefits of inclusion, particularly of spending informal time with more experienced colleagues and of the learning opportunities arising from such interactions. For example, a study of teacher interactions during break-time in an American school, illustrated that

sharing of professional knowledge and collaboration occurred during break times, allowing novice teachers to develop skills and an understanding of their profession (Mawhinney 2010). Likewise Fox, Deane, and Wilson (2010) highlighted that teachers learn informally through corridor conversations and by observing colleagues. Equally, in this current study interviewees reported on the value of informal meetings and of opportunities to take part in professional conversations.

Theories on the development of professional identity further emphasise the importance of social interaction by suggesting that identity construction results from professional socialisation (Monrouxe 2010; Rees and Monrouxe 2010; Henderson, Winch, and Heel 2006). The development of professional thinking and identity has been recognised as an important consequence of participation in clinical teams (Sheehan, Wilkinson, and Billett 2005; Dornan *et al.* 2007; Weaver *et al.* 2011; Crossley and Vivekananda-Schmidt 2009). While highlighting the importance of participation in shaping professional identity, Billett and Smith (2006) suggest a 'duality' in the relationship between the workplace and the individual. Since individuals play a role in refining and transmitting cultural practices in the workplace when these clash with their identity, that very identity is both shaped by and shapes the environmental norms and values.

Inclusion in a community of practice is also said to be important to the development of professional judgement. Coles (2002) argued that the foundation of professional judgement (i.e. deciding what is 'best' in the particular situation rather than what is 'right') is 'practical wisdom', not formally taught but acquired through experience and informal conversations with peers. Deliberation is essential for the development of professional judgement and entails seeing one's practice within wider existing traditions. According to Cole, one needs to be immersed in the traditions of that practice not merely to replicate them but to reconstruct them. Being included in professional conversations is therefore essential for the development of the professional judgement of trainee doctors. Likewise Billett (1996) has claimed that 'expertise' is developed through immersion in and familiarity with the norms and

practices of a particular social community. Developing expertise depends on access to and engagement with a social community.

This study has illustrated that inclusion and, in particular, the opportunities to participate in professional conversations facilitate the development of professional judgements, values and approaches to clinical care and work in general. It therefore supports Cole's suggestion that engagement with others is vital for the development of professional judgement but adds that such engagement also contributes to the development of professional values (for example, approaches to risk management , and staff management) and thus to the shaping of professional identity.

Finally, although this study demonstrated that 'expansive' training environments encourage trainees' participation, there was some evidence that engagement with the environment also depended on the personal characteristics of the trainee. In their critique of 'community of practice', both Kennedy *et al* and Fuller *et al* (Kennedy *et al.* 2009a; Fuller *et al.* 2005) argued that Lave and Wenger's theory assumes a largely passive role for learners. They suggested that learners have a choice about the nature and degree of their participation in the communities of practice they encounter and that prior identity is important in determining learning experience. Similarly, a number of the theoretical frameworks on workplace learning described in Chapter 2 also claim that both workplace characteristics and workers' prior dispositions (values, personal history, cognitive styles and attitudes) impact on opportunities to learn (Illeris 2004; Billett and Smith 2006; Billett 2009; Newton *et al.* 2011).

Other studies also identified that opportunities to participate are influenced by the characteristics of the individual learner and of the training environment. Fox, Deaney, and Wilson (2010), in a study of newly qualified teachers in schools, highlighted the interaction between the individual's sense of 'agency' and the 'expansive –restrictive' nature of the schools. The study suggested that some individuals were more proactive in finding support but also that support and informal learning opportunities varied, depending on the expansive nature of the school. Similarly, Boor *et al.* (2008), in a qualitative study of medical students in hospital

placements, showed that motivated students in departments which discouraged participation either became less motivated or gained opportunities through persistence, giving them a sense of achievement. Although a proactive nature affected 'participation', hospital departments that encouraged participation motivated the less proactive to participate. Similarly Kennedy *et al.* (2009 a,b) concluded that environmental (availability and accessibility of the supervisor) as well as personal (skills and desire for independence) factors affected decisions of students and junior doctors on whether or not to seek support.

This current study however did not explore the role of individual 'agency' and the way it interacted with the working environment. I acknowledge that this is a limitation of the study. Nevertheless, the findings suggest that regardless of the learners' personal qualities, the environment can 'afford' or 'restrict' participation which in turn may impact on learning opportunities and preparedness.

How this study adds to Lave and Wenger 'situated learning theory'

In summary, this study adds further evidence in support of Lave and Wenger theory. By assuming a position of a trainee within the practice, the trainee entered a 'community of General Practice'. It appears that their position as a trainee legitimated peripheral participation as over time, the trainee was expected to take on the clinical tasks and responsibilities expected of other community members. However the findings from the study further add to Lave and Wenger theory. They illustrated that participation can be enhanced or restricted. The presence of hierarchical relationship between members of the community can influence such participation regardless of the 'new comer' sense of agency. In such hierarchical communities, participation of 'new comers' may remain peripheral and will not progress to full membership in the community thus, restricting both their abilities to contribute and shape community values and behaviours and the opportunities available to them to learn.

The importance of inclusion and the ability to participate in a 'community of practice' is of a particular importance. Participation did not only prepare trainees to

the role of a General Practitioner by providing opportunities for them to participate in clinical work. Furthermore, participation facilitated understanding and development of professional judgements and values, assisted in identity construction and allowed the development of professional skills for example by allowing trainees to instigate and lead on changes relating to the work of the community. In this way participation in a 'community of practice' enhanced the preparedness of trainees to their future role as General Practitioners.

Finally, the findings from this study add to Lave and Wenger theory as they illustrate that participation of the trainee in a community of practice also encouraged them to keep on learning. Inclusive and less hierarchical working environments which encouraged participation, motivated trainees to learn and enhanced their sense of 'self direction'. This implies that participation in 'community of practice' in the workplace goes beyond preparing new comers to their new roles but rather is important in maintaining support and motivation for learning throughout one's professional career.

7.3.4 Supervision and workload and their relation to confidence and adaptability.

This study emphasises how important it is in building their confidence for trainees to feel adequately supported and supervised. Being trusted to work independently, when supervision in the form of support and guidance was readily available, boosted confidence. When guidance and support were not readily available, this reduced confidence by introducing doubt. This finding is supported by other researchers who also highlighted the need to achieve a balance between autonomy and supervision (Iedema *et al.* 2010; Busari *et al.* 2005; Hinchey *et al.* 2009).

Iedema *et al* (2010) concluded from in-depth interviews with junior doctors that the confidence to act independently grew when access to supervision and guidance was flexible and readily available. However, supervisors had to adapt to the changing needs of trainees. Hinchey *et al* (2009) found that autonomy of practice and ownership of patient management, coupled with support from seniors, were

instrumental in preparing trainee internal medicine physicians for independent practice. Similarly an earlier survey study of medical students (Busari et al. 2005), illustrated that good supervisors were approachable, non threatening, enthusiastic and allowed trainees to have appropriate levels of autonomy.

Other researchers reported that trainees' decisions to seek support are influenced by the desire to maintain professional credibility and a positive image of professional competence in the eyes of their supervisors (Shakespeare and Webb 2008; Stewart 2007; Kennedy *et al.* 2009b). Presenting a plan and seeking reassurance for its use were part of a strategy to maintain professional credibility (Kennedy et al 2009b). The findings from this study partially support these conclusions. Although I did not set out to investigate when it is that trainees seek support, interviewees did emphasise their need for autonomy (being trusted to work independently) as well as their desire for guided decision-making and reassurance. Presenting a management plan and seeking reassurance for it from supervisors, was a common strategy reported by interviewees and supported them in becoming confident and self directed.

A heavy workload had both positive and negative impacts on preparedness. On the one hand, it provided opportunities to develop strategies for dealing with heavy workload which assisted adaptability to future work. On the other, it reduced personal study time and opportunities to participate in different aspects of General Practice work, such as audit and business matters, and in informal meetings thereby having a negative effect on preparedness. This finding is in line with the Stok-Koch, Bolhuis and Koopmans (2007) study of trainee nursing home physicians. They also found that trainees reported that a heavy workload both impeded learning and paradoxically provided learning opportunities. Similarly Jelinek et al (2010), in a study of junior doctors in emergency departments in Australia, also reported that learning opportunities were affected by heavy service demands which reduced opportunities for supervision and feedback.

7.3.5 The role of the trainer in fostering confidence and adaptability

This study also identified that the role of the trainer was pivotal in building trainee confidence. A good honest relationship fostered confidence through appropriate support and challenge. Respect for the trainee's own professional approach assisted in building confidence and consequently a perception of being prepared. Conversely, conflicts between trainer and trainee at times reduced confidence and support in addressing learning needs, thereby restricting professional development. Conflicts meant that trainers were not supporting trainees in addressing their learning needs.

The trainer also had an important part to play in teaching effective communication skills which in turn enhanced adaptability and confidence in dealing with diverse patients.

Trainer-trainee relationship

The importance of trusting relationships between trainees and supervisors is supported by others who also identified trusting relationships to be important for learning as they eased access for advice, support and supervision (Fernald *et al.* 2001; Cornford and Carrington 2006; Victor Smith 2004; Cottrell *et al.* 2002; Kilminster and Jolly 2000). That type of relationship has been reported to enhance the development of gradual independence of medical students (Van der zwet *et al.* 2010; van der Zwet *et al.* 2011), to foster reciprocity, with trainees being more likely to learn from negative feedback (Crommelinck and Anseel 2013) and to positively influence the construction of a professional identity (Deppoliti 2008).

This present study illustrates that the provision of encouraging feedback on performance by the trainer, the confidence of the trainer in the trainee, the ability of the trainer to adjust feedback to the needs of trainee, balancing support with challenge during tutorial all enhanced trainee's confidence. Tutorials provided an arena for trainees to reflect on their clinical experience with the support and guidance of an experienced GP. Tutorials offer, in the words of Vygotsky (1978), a 'zone of

proximal development' (described in section 7.3.1) as well as time for trainees to reflect on their practice. Schön (1983) emphasised the importance of reflection for learning. Challenge experienced during tutorials helped trainees to 'reflect on action', as suggested by Schön employing past events and lessons to inform future practice. This study indicates that, although challenge during tutorials was important, it had to be balanced with support and adjusted to trainees' needs for it to enhance confidence.

The findings support Smith (2004) who highlighted trainees' need for comfort prior to challenge during tutorials and van der Zwet *et al.* (2011) who suggested that tutorials were most useful when challenge was delivered in a non-judgemental manner.

Trainers who assisted trainees in identifying their learning needs during tutorials and supported them in addressing those needs helped them to develop both skills and confidence in their abilities. Respecting a trainee's own professional approach was of particular importance for trainees' professional development and confidence. Similarly Stok-Koch, Bolhuis, and Koopmans (2007) reported that trainee physicians commonly cited a lack of encouragement from supervisors for the development of their own style as an impediment to learning.

Conflicts between trainee and trainer resulted from a clash of ethos or of conflicting professional values and often affected trainee confidence. Trainees did not seem to adopt an ethos that conflicted with their own values, preferring to employ strategies for dealing with such conflicts. However, conflicts meant that trainees were unable during training to develop a professional approach which fitted with their own values. In this way, conflicts restricted the development of professional identity and values.

The notion that conflicting values can impede confidence and that learners are unlikely to conform to an ethos that conflicts with their own is supported by literature on the development of professional identity. Monrouxe (2010) suggested that when personal values of doctors conflict with professional values in the

workplace this can result in an identity dissonance. Such dissonance can lead to powerful emotional disruptions that include uncertainties about abilities, ambitions and self-worth. Similarly, a study of learning in General Practice (van der Zwet *et al.* 2011) reported that when medical student could not identify with the values of supervising GPs, this reinforced their own ideas on professionalism and made them feel less secure and uncomfortable.

Studies of other professions also reported on the way learners interact with a working environment that conflicts with their personal ethos. Ibarra (1999), in a study of learners in the finance industry, found that although learners observed 'normative practice' they more readily adopted practices that fitted in with their own beliefs. Similarly in this study, there was evidence that trainees were selective in the attributes and behaviours of trainers they chose to adopt or emulate.

Boyчук, Duchscher and Cowin (2004), in their investigation of the transition of newly qualified nurses into professional practice, suggested that antagonistic seniors and a work ethos in conflict with what nurses had been taught resulted in moral distress, impacted on the development of professional identity and led nurses to leave the profession. Research in the fields of organisational behaviour and teaching also suggests that a good congruence between the individual and the culture, norms and values of the working environment has a positive effect on both the individual and the environment, resulting in higher job satisfaction, better socialisation of employees within the organisation, greater motivation and improved retention of employees (Chatman 1989; Chatman 1991; Noyes 2008).

The finding that trainees employed strategies to cope with or minimise conflicts of ethos (changing consultation style during assessment, rationalising differences or choosing not continuously to disagree directly with trainers) is shared by other researchers. Myrick (2006), exploring conflicts in the field of professional education (medicine, nursing and social work), illustrated that conflicts between trainees and supervisors were not always brought to the surface. Began (2001), in a qualitative study exploring the process of professional socialisation, noted that although every medical student interviewed reported seeing things they did not agree with, they

remained silent as long as there was no direct patient harm, albeit noting to themselves that this was behaviour they should not adopt. Such conflict between trainees and supervisors were suggested to reflect a power-hierarchical relationship (Myrick *et al.* 2006).

The finding that a conflict or lack of congruence of ethos occurs primarily in Practices where trainees feel less included is supported by Handley *et al.* (2006) who suggested that opportunities to participate fully in a community of practice depend on the 'fit' of its values with the sense of the learner's self. They argued that, when newcomers experience a conflict in relation to a role or practice they are expected to adopt, they may choose to maintain a marginal participation or even not to join the community at all. Conversely, Lave and Wenger (1991 p.54) view conflicts between newcomers and existing members as an inevitable power struggle arising from the negotiation of new goals. The finding that GP trainees felt less included in Practices whose ethos conflicted with their own may imply that learners have a sense of 'agency', choosing even unconsciously to limit their participation in communities that do not fit in with their personal ethos. Participation, therefore, may depend not only on the opportunities afforded by the community but also on the willingness of the 'agent' to adapt and change.

Finally, however, this study revealed that differences in ethos did not always result in conflicts. When the trainer acknowledged and respected the differences in ethos or values and allowed the trainee the freedom to develop an independent professional approach, conflicts did not occur. Similarly conflicts were not brought to the surface when the trainee chose to adapt, even temporarily, to the ethos or approach of the trainer.

7.3.6 Aspects of the training Practice not affecting preparedness

Interviewees described a number of the aspects of their training Practices which did not have a direct bearing on preparedness but may at times have influenced their learning or experience. These are outlined below:

‘Practice-patient relationship’, ‘Relationship between doctors’, ‘Relationship with Practice staff’

When describing their training Practices, interviewees talked about the relationships between Practice and patients, between the doctors in the Practice and between the doctors and their employed staff. There was some evidence that these may, on occasion, have impacted indirectly on learning. Thus, for example, Practices that knew their patients well were better able to support trainees in managing these patients. Tense or poor relationships between doctors, at times, had a negative impact on training by reducing opportunities for informal meetings and for the learning resulting from them. Nevertheless, being exposed to difficult relationships, albeit unpleasant for the trainee, did provide a learning opportunity as it enabled them to see how difficult dynamics were negotiated. Likewise, although tense relationships between doctors and employed staff resulted at times in an unpleasant atmosphere, there was no evidence that this affected training or the perception of being prepared.

‘Organisation of work’

Poor organisation of work did not seem to affect preparedness although it increased workload and stress for all doctors. It was reported to have some negative effect on training by reducing personal time for learning.

‘Caring and support for trainee’

Pastoral support or personal support accounted for a positive training experience and assisted trainees through difficult situations or life circumstances. However, it was professional support which impacted on preparedness through building trainees’ confidence in dealing with adverse events.

‘Having more than one trainer’

Having more than one trainer in the Practice was not shown to impact on preparedness. Although having an additional trainer potentially provided more than

one perspective on clinical management and work place based assessment, in inclusive training Practices these benefits were derived from interaction with non training partners.

‘Personal qualities of the trainer’

The personal qualities of the trainer (‘the trainer as a doctor’, length of experience as a GP, commitment and enthusiasm for teaching) did not impact on preparedness. So for example, having a more experienced or committed trainer did not make the trainee feel better prepared. Nor did they account for a particularly positive or negative training experience.

‘Personal relationship with the trainee’

Having a close personal relationship with the trainer was not in itself considered important by all interviewees. Rather the nature of the relationship was important. Trusting, honest, non-hierarchical relationships were good for learning and supported preparedness.

7.4 Summary

This Chapter summarised the research findings and discussed them in view of existing literature. Confidence and adaptability were identified as central tenets of preparedness. The inclusive nature of the Practice, supervision and the GP trainer were the main aspects of the training Practice impacting on preparedness. Bandura’s theory of ‘self efficacy’ and Lave and Wenger’s theory of ‘situated learning’ were used to discuss the findings. The importance of balancing support and guidance with autonomy was highlighted and the role of the trainer in supporting preparedness was discussed in light of published research.

Chapter 8: Trustworthiness, limitations, utility and final conclusions

This Chapter discusses the trustworthiness of the research findings. The limitations of the study are outlined and suggestions are provided as to the way the findings can be used to inform policy on quality assurance of doctors' training and in the design of General Practice Training Programmes. I conclude by suggesting areas for further research.

8.1 Trustworthiness of research findings and reflection on the research methods

Theoretical considerations relevant to the methodology and methods used in this study were discussed in Chapter 3. The following section discusses the trustworthiness of the findings that emerged from this research.

Trustworthiness was supported by a clear and detailed description of case selection, data collection and data analysis and by interviewing two different cohorts of informants (GP trainees and early career GPs). In addition, the initial coding framework was triangulated against that generated by another medical educationalist. The use of 'constant comparison method', with emerging themes being compared from case to case, further enhanced credibility. Twenty seven interviews enabled theme saturation to be achieved (a process described in Chapter 3). The use of Nvivo software facilitated the handling of a large amount of data and the comparison of cases. It also allowed memos to be written and related to particular interviews which further supported the development of the thematic framework and the presentation of data in the form of Charts.

I continued to sample in order to achieve sufficient variations, including interviewees experiencing various degrees of difficulty, UK and non-UK graduates and those who

trained in Practices of different sizes and in different locations. This enhanced the transferability and applicability of the findings.

Although a number of telephone interviews were used, in addition to face-to-face interviews, this did not seem to affect the quality of the interviews. I observed no differences between telephone and face-to-face interviews in terms of length or depth, perhaps because three out of the five telephone interviews were conducted in the evening. This was further confirmed by the medical educationalist who coded both face-to-face and telephone interviews but was unable to differentiate between them. Similarly, there were no differences in the ways early career GPs and trainees described their training Practices or talked about preparedness.

Respondent validation approach, with the findings being discussed with a group of trainees, and the thematic framework shared with a group of educationalists, further enhanced trustworthiness of the findings. This challenged my own understanding and interpretation of the data and helped to refine the thematic framework. It reassured me that the meanings I attached to the data were not my interpretation alone. The findings were also presented at two conferences, one aimed at GP trainers and the other at medical education researchers.

Nonetheless, trustworthiness could have been enhanced in a number of ways. Dependability could have been improved by independent coding of all interview data by two researchers. I considered this approach but as the separate coding of three interviews by me and another medical educationalist did not reveal substantial differences, I did not feel it justified the significant demand associated with such a task. Instead I opted for sharing the themes and some of the supporting texts with a group of educationalists on completion of the initial thematic framework, with a view to refining it.

Although I was concerned that my own involvement in the quality assurance of GP training might bias the way interviewees talked about their training Practices, this did not seem to be the case. A number of interviewees did not train in my Deanery and,

therefore, were not familiar with my role. Invitations did not attract primarily those trainees who experienced difficulties during their training so that interviews portrayed a broad range of experiences. I was conscious that not being a GP myself might affect the way interviewees talked to me. It is difficult to discern in retrospect whether that happened but my own feeling was that not being a GP was an advantage as interviewees were more open and less anxious, perhaps because they were less worried about being judged or about maintaining professional credibility.

I appreciated that the wording of the questions could have had a bearing on the answers, an inevitable aspect of any qualitative research using focus groups or interviews. I tried to ask broad and open questions, guided by what the interviewees were describing, probing them to reflect in depth on issues they raised themselves. Nevertheless, at times, particularly if interviewees were less open and forthcoming at the outset, I did ask some probing questions.

As detailed in Chapter 3, alternative methods could have been used in the study. In particular, the inclusion of other sources of information, such as observational data from Practices or interviews with other informants within Practices, using a case study approach, could have enhanced the trustworthiness. The difficulties associated with these approaches were already outlined in Chapter 3. In addition, it would have been difficult to sample in advance training Practices in which trainees had contrasting experiences (positive or negative). Furthermore, General Practices tend to have a dynamic nature and it is possible that relationships and partnerships in training Practices of early career GPs would have changed. Interviewing in such Practices may not truly portray the experiences of trainees who completed training six months to two years earlier.

Focus groups could have supplemented or substituted for interviews. However, focus groups are less useful in the investigation of sensitive data and I was not confident that doctors would discuss negative training experiences in this format. I consider that overall the method used to answer the research questions was appropriate. The advantage of in-depth interviews lies in the breadth and richness of the data yielded.

They enabled a thoroughgoing investigation of the research questions and prompted interviewees to reflect deeply on the questions asked. Interviews provided an intimate space for trainees to share personal and private experiences and were particularly useful when experiences were negative. Indeed, a number of interviewees admitted that they had never before discussed their training experiences in such depth.

8.2 Limitations of this research

There are a number of limitations to this study which need to be considered. First I believe the sampling frame represented the full range of training Practices (in terms of size and location) and of trainees (in terms of country of origin and length of training). The almost equal number of male and female interviewees does not, however, reflect the gender split of the more recent cohorts of trainees where females predominate. In addition, a greater number of GP trainees are now training part time. I included neither part-time trainees nor those who required an extension to their training. It is possible that these categories, with their distinct perspectives, might have added an extra dimension to the study. For example, does working part-time affect inclusion? The absence of specific information makes it difficult to confidently apply the findings to these groups of trainees.

Although the study was limited to Scotland, I considered its findings relevant at that time to General Practice training elsewhere. Nevertheless, it is unclear how current organisational changes in health care in England will impact on the training environment in General Practice. This study was not undertaken in the context of such changes which will need to be investigated in the future.

The identification of adaptability as a central tenet of preparedness is possibly a reflection of the fact that interviewees were early on in their career with adaptability for future work being a major concern to them. It may also reflect the job market at the time, as a number of interviewees were looking to undertake short-term or

flexible employment on completion of their training. This is, nevertheless, an important finding as it challenges the traditional idea that training should equip trainees to become GP partners. Indeed workforce statistics already show an increase in the number of GPs working on a sessional or salaried basis (ISD 2009. ISD 2012).

Similarly, it may be that the finding that inclusion is important for preparedness was shaped by the characteristics of the interviewees, the majority of whom were in their early 30s, a generation often referred to 'generation Y'. Generation Y has been deemed to have a high degree of self-value, to expect respect and to emphasise social interaction and team work, with positive relationships in the workplace being extremely important to them (Hewlett 2009; Borges *et al.* 2010; Lavoie-Tremblay *et al.* 2010; Cubit and Ryan 2011; Laurence *et al.* 2010). It is not surprising, therefore, that this study confirmed the significance attached by interviewees to inclusion, respect, support and team work.

A further limitation of the study is that it did not investigate the ways in which personal attributes, traits or histories may have influenced the perception of being prepared or the engagement with the environment. McManus, Keeling and Paice (2004) suggested that the way doctors perceive their workplace environment can be predicted by their personality traits and their approach to learning. They illustrated, for example, that doctors reporting a heavy workload tended to learn superficially and were high on personality traits of neurosis while low on conscientiousness. My study did not consider the way personality traits of doctors affected the way they described their training environment or their understanding of preparedness. There was however some evidence during the interviews that personality or motivation influenced involvement and interaction. This did not appear in all interviews and was not investigated in depth. The focus of the study remained the description of the training environment and the way it was perceived to impact on preparedness. Like others (Illeris 2004; Billett 2009; Billett and Smith 2006; Newton *et al.* 2011), I acknowledge that the role of 'personal agency' can influence engagement and perceptions of preparedness but I would suggest that, regardless of personal qualities

and varied intentions, the training environment has the potential to impact on preparedness.

Finally, the meaning that GP trainees and early career GPs attach to 'preparedness', although a contribution to understanding the concept, may not of itself be sufficient to explain it. A comprehensive understanding of preparedness needs to take into account the perspectives of other stakeholders such as experienced GPs, hospital consultants, patients and external agencies.

8.3 Utility of research findings

There are a number of ways in which the research findings can be utilised.

First, current GMC standards for training used by Deaneries to evaluate the quality of training provided by General Practices focus on formal and measurable aspects of training such as protected time for formal teaching, induction, compliance with the European Working Time Directive, equality and diversity, workload, supervision arrangements, quality of feedback, and availability of educational resources. This current study has identified 'inclusion' as an important characteristic of a training Practice. Training Practices which were characterised by less hierarchical relationships between the doctors and that were more progressive and open to new ideas were also more inclusive of trainees, 'affording' them the opportunities to take part in a wider range of General Practice work, thereby better preparing them for their future role. These elements are not currently examined under the quality assurance framework used to assess GP training in Scotland as the framework is based on GMC standards. I am hopeful that the dissemination of these findings will feed into policy development in the field of quality assurance and its assessment.

Secondly, the RCGP has recently argued for the extension of training to include an increase in the time trainees spend in General Practices from 18 months to two years in order to better prepare GP trainees for their future role. This study suggests that in order to address the recent concern raised by the RCGP regarding the lack of

preparation of trainees, it is perhaps not sufficient simply to extend the period of training. It is important that trainees spend time in inclusive training environments which allow them to take an active role in both clinical and non-clinical aspects of General Practice, as well as to influence and even lead on changes to services. In such environments, trainees can better develop clinical and leadership skills. What matters is not simply the length of time spent in training but rather the nature of the training environment, the opportunities afforded to trainees and their engagement in such opportunities. These issues should also be at the heart of any quality assurance framework.

Thirdly, this study illustrates that an understanding of the business aspects of General Practice enhanced confidence and thereby the perception of being prepared. In the context of training in Scotland, business aspects related primarily to local Practice finance, staff management and partnership dynamics. The plans in NHS England for GP Practices to commission services will extend the business- managerial roles of GPs and their need to understand these processes. The requirement for GP trainees to make sense of finance and business and of their link to health outcomes is likely to grow. Although the Scottish Government has as yet no plans to introduce such changes, this study indicated that the involvement of trainees in business matters, even at Practice level, is useful preparation and that inclusive training Practices tended to afford greater opportunities for involvement in business aspects.

Fourthly, the study adds that preparedness is also defined as the ability to adapt to future work. Postgraduate training should take into account the importance of adaptability as an outcome of training, particularly since many GP trainees do not take on a partnership post on completion of training, preferring a locum or short-term salaried posts. The ability to adapt is also important in view of ongoing changes in the NHS where one has continuously to adapt to new directives and regulations.

The value of training in more than one Practice when it comes to flexibility for problem-solving and broadening perspectives in clinical and non-clinical work was highlighted by this study. Training in more than one Practice meant that trainees were more adaptable, a finding with implications for planning future programmes.

Currently, many trainees spend all 18 months in one GP Practice. This study suggests that training in more than one Practice improves preparedness and adaptability. Hence, an important implication from this study is that Deaneries should include placements in two different practices in their General Practice speciality training programmes.

Finally, in order to enhance the utility of the study, I suggest that the findings are further shared with postgraduate medical educators, particularly GP trainers and those responsible for the training of prospective GP trainers. The importance of the inclusive nature of a practice can be emphasised for example, while training GPs to become GP trainers and during courses offered to existing GP trainers. The findings from the study have already been published (Wiener-Ogilvie, Bennison and Smith 2014) which should aid dissemination and my intention is to further present the findings in conferences and training events.

8.4 Suggestions for further research

Reflecting on the study design, data collection and findings, further research can build on this study in a variety of ways. First, as mentioned earlier, further research into preparedness should seek perspectives from stakeholders such as secondary-care clinicians, experienced GPs, patients and social agencies regularly engaged with primary-care services. Their perspectives could go beyond the current view of trainees and early career GPs which concentrated on confidence and adaptability.

Secondly, it would be useful to examine whether the findings from this study are transferable to learners in other settings such as other postgraduate specialty trainees. It is particularly noteworthy that much of the published research on hospital training focuses on junior learners. Are confidence and adaptability, for example, perceived to be central elements of preparedness for other speciality trainees? Similarly, it would be useful to examine whether those aspects of the training environment illustrated in this study to impact on preparedness, are applicable to other clinical

training environments. Does inclusiveness of the training environment, for example, enhance the preparedness of specialty trainees or other learners in clinical settings?

Thirdly, as highlighted earlier, where this current study focuses on the role of the environment in enhancing preparedness, there is a need to investigate the influence of ‘personal agency’ and personal dispositions on the ways in which individuals perceive and interact with their training environment. Such personal dispositions may shape individuals views on what it means to be prepared and the way they access learning opportunities in their training environment.

A number of intriguing issues not central to this study that were raised during interviews merit further investigation. When describing their Practices, interviewees reflected on the relationship between the Practice and patients and on issues such as continuity of care, patient centredness and the business orientation of the Practice. It was difficult to ascertain whether these factors impacted on training. It was unclear, for example, whether a strong business emphasis had a negative effect on training or preparedness. Similarly there were suggestions that poor relationships between doctors, poor organisation of work and heavy workload may impact on patient care, all points worthy of further exploration.

Finally, I was aware throughout this study of the major changes and challenges being faced by the NHS, particularly in England, and by medical education in the UK as a whole. ‘The shape of training’, a major review of postgraduate medical training, is due to publish its findings in the autumn of 2013. At the time of writing, the review’s proposed changes and their potential impact on General Practice training are unknown. In addition, this study did not take into account the context of service commissioning in NHS England. Future studies may be needed to assess the impact of such changes on the training environment of GPs and doctors in general. Changes in the needs of the NHS and in service delivery may also shape the views of GPs and doctors on what it means to be prepared. The findings of this study may need to be revisited in light of these changes.

8.5 Conclusions and final thoughts

1. The findings from this study suggest that GP trainees and early career GPs describe their training Practices in terms of their inclusive nature, the Practice ethos, the importance of training and the GP trainer.
2. Although interviewees were not unanimous in describing preparedness, the meaning they attributed to it centred around the two main elements of confidence and adaptability. The ability to manage varied, complex patients and workloads as well as the possession of good consultation skills and an adequate knowledge base assisted trainees to adapt to future work and augmented confidence in their own abilities. Working independently, being self-directed and gaining an understanding of business and partnership aspects of General Practice also enhanced confidence.
3. The extent to which Practices included trainees impacted significantly on preparedness, with Practices characterised by less hierarchical relationships between doctors, by a progressive nature and by good team work being especially inclusive, supportive and approachable, affording trainees opportunities to take part in the broader aspects of General Practice. Inclusive Practices also enhanced trainees' adaptability and offered better opportunities for 'enactive mastery', 'vicarious modelling' and 'verbal persuasion', thereby boosting confidence. They allowed trainees to lead on identifying and addressing their learning needs and were better in supporting them in the development of their own professional approach and identity.
4. Supervision and support appropriate to need and opportunities for guided decision-making enhanced confidence.
5. The trainer had a pivotal role in building trainee confidence and in enhancing adaptability through the teaching of effective communication skills.

Some final thoughts:

Throughout this study, there was evidence that the training year provided an opportunity for trainees not only to learn new skills but also to observe and reflect on the values and ethos of the individual GPs and of the Practice as a whole. Their expectations for the future were shaped by their training Practice experience but also by their own personal values and ethos. Thus, for example, many interviewees expressed a desire to work in environments that were inclusive, co-operative and receptive to change and which fostered opportunities for informal interaction and mutual learning among the doctors. It is likely that the personal values and ethos of the newly qualified GPs will in turn shape the values, ethos and identity of General Practice in the future. The way individuals develop their own identity and their efforts to contribute to and shape the identity of their community of practice has been described by Wenger (1998) as 'identification-negotiation duality', the implication being that tensions between the individual's values and identity and those of the community of practice are inbuilt. Duality in the relationship between the individual and the environment was also identified by Billett and Smith (2006). It is therefore likely that newly qualified GPs will determine the future identity and ethos of General Practice as a 'Community of Practice'.

Finally, with the introduction of changes to the NHS in England, it is possible that the work environment for which trainees are now being prepared will be different to today's. The future of General Practice is likely to be shaped not only by policy changes but also by the values and expectations newly qualified GPs bring to their work environment.

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Appendices

Appendix 1: Characteristics of interviewees and their training Practices

Name of interviewee	Status	Medical school	Completed UK foundation training programme?	Age at time of interview	English native language?	Gender	Length of GP training	Time in General Practice during training	Training Practice list size (approximate number of patients on training Practice list)	Training Practice population	Rural classification	Other information
1.Kay	In training	England	Yes	28	Yes	Female	36 months	12 months	7000 and above	Mainly affluent	Large Urban	
2.Eleanor	Completed	Scotland	UK Pre-foundation	32	Yes	Female	36 months	12 months	7000 and above	Mixed	Large Urban	
3.Arvind	Completed	Other-Asian	No	30	No-English second language.	Male	36 months	12 months	5000-7000	Mainly deprived	Other urban	
4.Andrew	In training	England	Yes	30	Yes	Male	36 months	12 months	7000 and above"	Mainly deprived	Large Urban	Information relates to his main training Practice. He also trained for a short period in Barbara's Practice.
5.Grant	Completed	Scotland	UK Pre-foundation	29	Yes	Male	24 months	12 months	7000 and above	Mixed	Large Urban	

Name of interviewee	Status	Medical school	Competed UK foundation training programme?	Age at time of interview	English native language?	Gender	Length of GP training	Time in General Practice during training	Training Practice list size (approximate number of patients on training Practice list)	Training Practice population	Rural classification	Other information
6.Alex	In training	Scotland	UK Pre-foundation	29	Yes	Male	36 months	12 months	7000 and above	Mixed	Accessible Rural	
7.Kevin	In training	Scotland	Yes	29	Yes	Male	36 months	12 months	7000 and above	Mixed	Large Urban	Trained in the same Practice as Sange.
8.Barbara	In training	England	UK Pre-foundation	34	Yes	Female	24 months	18 months	7000 and above	Mainly affluent	Large Urban	Information relates to her main training Practice. She also trained for a short period in Andrew's Practice.
9.Raj	Completed	England	UK Pre-foundation	41	Yes	Male	36 months	12 months	7000 and above	Mixed	Large Urban	
10.Geraldine	Completed	Scotland	UK Pre-foundation	29	Yes	Female	24 months	12 months	7000 and above	Mainly deprived	Other urban	
11.Erica	Completed	Scotland	Yes	29	Yes	Female	36 months	12 months	5000-7000	Mainly deprived	Other urban	
12.Pamela	Completed	Scotland	Yes	29	Yes	Female	36 months	12 months	7000 and above	Mainly affluent	Large Urban	
13.Fatima	Completed	England	Yes	30	Yes	Female	36 months	12 months	7000 and above	Mainly deprived	Large Urban	
14.Karen	Completed	Scotland	UK Pre-	29	Yes	Female	36 months	12 months	5000-7000	Mixed	Large Urban	

Name of interviewee	Status	Medical school	Competed UK foundation training programme?	Age at time of interview	English native language?	Gender	Length of GP training	Time in General Practice during training	Training Practice list size (approximate number of patients on training Practice list)	Training Practice population	Rural classification	Other information
			foundation									
15.Sange	Completed	Other-Asian	UK Pre-foundation	31	No-English second language.	Male	36 months	12 months	7000 and above	Mixed	Large Urban	Trained in the same Practice as Kevin.
16.Michelle	Completed	Scotland	UK Pre-foundation	31	Yes	Female	36 months	12 months	5000-7000	Mainly young-student	Large urban	
17.John	Completed	Other-European community	UK Pre-foundation	35	No-English second language.	Male	24 months	12 months	up to 5000	Mixed	Remote rural	Trained in 2 Practices. Information relates to the small rural Practice. He also trained in a larger Practice which was in a 'remote small town'.
18.Becca	In training	Other-African	Yes	34	No-English second language.	Female	36 months	12 months	7000 and above	Mainly deprived	Large Urban	Trained in 2 Practices. Information related to her first training Practice ('large

Name of interviewee	Status	Medical school	Competed UK foundation training programme?	Age at time of interview	English native language?	Gender	Length of GP training	Time in General Practice during training	Training Practice list size (approximate number of patients on training Practice list)	Training Practice population	Rural classification	Other information
												urban') .She also trained in a second Practice ('other urban) which had more of a mix population.
19.Paul	Completed	England	UK Pre-foundation	40	Yes	Male	24 months	12 months	up to 5000	Mixed	Remote Rural	
20.Sabil	In training	Other-Asian	Equivalent to UK foundation.	35	No-English second language.	Male	36 months	18 months	up to 5000"	Mixed	Other Urban	
21.Samuel	In training	Scotland	Yes	29	Yes	Male	36 months	18 months	7000 and above	Mixed	Large Urban	Trained in two Practices. The information relates to his second Practice. His first Practice, was also 'large

Name of interviewee	Status	Medical school	Competed UK foundation training programme?	Age at time of interview	English native language?	Gender	Length of GP training	Time in General Practice during training	Training Practice list size (approximate number of patients on training Practice list)	Training Practice population	Rural classification	Other information
												urban' but with affluent population.
22.Oliver	In training	Scotland	Yes	29	Yes	Male	36 months	18 months	5000-7000	Mixed	Accessible small town	
23.Gerard	In training	Scotland	Yes	29	Yes	Male	36 months	18 months	7000 and above	Mixed	Other Urban	
24.Felicity	In training	Scotland	Yes	30	Yes	Female	36 months	18 months	up to 5000	Mixed	Accessible small town	Trained in 2 Practices, both in 'accessible small towns' and of the same size and population.
25.Emily	In training	Scotland	Yes	31	Yes	Female	36 months	18 months	5000-7000	Mainly deprived	Other urban	
26.Judith	Completed	Scotland	UK Pre-foundation	31	Yes	Female	36 months	12 months	7000 and above	Mainly affluent	Remote Rural	
27.Sarah	Completed	Scotland	Yes	31	Yes	Female	36 months	12 months	7000 and above	Mainly deprived	Large Urban	

Appendix 2: Interview topic Guide

A number of Questions were added or removed following the conduction of the first 3 interviews. These questions are marked in red.

Additional background questions were added at the beginning:

How old are you?

When did you finish medical school?

Where and when did you do foundation programme?

When did you start GP training?

How many months have you spent in General Practice during your training?

Is English your first language?

For early career GP:

What do you do now?

Main questions:

1. Tel me about the Practice you trained in? (if needed use probing questions such as , what was the relationship between the Practice team and how it affected you as a trainee, what was your place within the team, rainees contribution to decision making, control over work?)
2. What sort of issues are (or were) important to the doctors working in the Practice?
3. What features of the Practice do you feel are (or were) particular good for training and why?
4. What aspects of the Practice made training difficult and why?
5. What does 'being prepared' (to practice as a GP) mean to you?

The following question was added:

6. What were the main challenges for you in the first year following completion of training? (or what do you feel are the main challenges for you in the next year-for doctors still in training).
7. How would you know that you are ready to work as a GP?
8. What aspects of the Practice do you feel are (or were) particularly good in preparing you for your future role as a GP?
9. Can you describe particular experiences which were particularly preparing?

The following question was removed:

What did a good day look like in terms of your learning opportunities? What was a bad day like?

10. Can you tell me about a situation where you felt unease / uncomfortable in the practice (or a difficult situation you encountered in the Practice)?

11. [If was not mentioned before] Can you tell me about your trainer?

The following alternative questions to the question above were added:

- What aspects of the trainer were particularly good for training?
- What aspects were less good?
- How would you describe the trainer professional approach?

Appendix 3: An example of an interview

Interview 3: Eleanor (early career GP~0

S: Sharon Wiener-Ogilvie

T: Trainee (interviewee)

S: I just need to ask you some questions about yourself – when did you finish medical school?

T: I finished medical school in 2004 in the summer.

S: And you did your foundation in Scotland?

T: I did. I was the old style PRHO. I was the last year of pre-registration, so I only did the one year as a pre-register doctor. It was only one year pre-SHO

S: And how long did you work in hospital before you started GP training.

T: Just my pre-registration year.

S: Just the one. And so you started GP training in ...

T: 2005

S: And you just did 12 months in general Practice?

T: That's right - that was before the extra 6 months was introduced. I did my training in Edinburgh:

S: And...English is first language. What do you do now?

T: Pre Ewan being born, I was a locum GP, mostly part time. And quite a mixture of long term and short term locum posts. So that finished doing a long term locum in xxx, which I only finished because I had to leave to have him.

S: Just to start off, if you could tell me a little bit about your training Practice, what are they like, what was the practice like?

T: Overall, the practice was good. They were predominantly a partnership with I think 2 salary GPs when I was there and there was just me as a registrar, however, I know in the past they had had two, so there were two trainers at the practice. I think during the year and after the year, I might have had slightly different opinions on what they were like to work with. I think after the year that moving onto different practices, I felt more welcome and supported even as a locum. So I found the practice, I found it quite hard sometimes to feel 100% welcome to ask for advice. I was quite, I'm not a majorly outgoing person, but I'm not seriously shy either. I did sometimes feel a little bit intimidated, particularly if people felt they were being interrupted, which was a little bit tricky at times. I think however, that the teaching itself was very good. And I've no doubt that I was prepared well for the exams.

S: When you say the teaching, what do you mean by that?

T: I think that I was pushed hard.

S: *So that's on the clinical side? Or is that kind of during tutorials?*

T: During tutorials and clinical – for me it was good, because it did push me to learn. It pushed me on a knowledge basis and I guess also on a personal basis, with how stoical I was. I had quite a difficult year, I had been getting treated for depression just before starting and I found that year very difficult as a result of that, but also with perhaps not having at the time, the confidence to own up and say I'm having difficulties with this and that.

S: *So how were they, were they aware of those issues?*

T: Yes, they were.

S: *And how did they work with that knowledge?*

T: Initially I'm not sure there was a great deal. There was quite a bit of sympathy initially, of "that must be very difficult". I think at times it was perhaps forgotten – my learning style was clearly very different from that of my trainer. I'm very reflective – I still am. It's the way I learn and I find it very useful for me. She was very much an activist and she very much pushed and I think at times it was perhaps a little bit too much for me. There were a few tears on occasions.

S: *When you say she was an activist, what do you mean by that?*

T: She could be quite...what's the nicest way to put this? She could be quite, bolshy. I'd not necessarily use the word intimidating; I think that was perhaps me taking on a little bit of how I was feeling at the time. She was very straight to the point. There was no beating about the bush.

S: *But it felt like that at the time?*

T: Yes, it did a little bit. And in fact at the time, I think my reaction to this was taken as not coping round about the Christmas period of my registrar year. At the time, said trainer had suggested that I perhaps go part time in order to cope. Whereas I felt that I was probably ok, but I could have done with a bit more of the touchy feely side of the trainer at that point.

S: *You had contact mainly with the one trainer?*

T: The one trainer. The other trainer, yes I did have contact with. Again, she was approachable at times, but not always. I have to say the most supportive environment in the practice was that of the salary GP and the retainer they had, who I'm still friends with. I mean, they were fantastic and I used to often speak to them more. Which was a wee bit of a shame.

S: *In terms of what the practice was like size wise and population.*

T: I'm trying to remember. It was probably about 8000. I think they're a reasonably big practice, not terribly deprived. So a mixed population really. Nothing like the deprivation I worked with at xxx. Which I did actually enjoy a little bit more. Quite a mixed practice.

S: *What did it feel like in terms of – there were two trainers?*

T: Yes

S: *And how experienced were they?*

T: They were very experienced. I think they had been with the training programme for a long time.

S: *You said that you moved on to locuming. What were the differences, can you tell me a little bit about those differences and how you found them.*

T: The most basic thing was that a lot of the other places I chose to work. I wouldn't work in a practice, I would never go back if I didn't like it. That was one of the beauties of being a locum. Practices that I did find myself working at regularly they very basically spoke to each other outwith surgeries, not just on a professional basis but there was social chat, they met for coffee. There was actual contact with people on a friendly basis. So if you had a difficult morning, you could sit down with them and go "that was awful" and talk about some of the patients you had seen with a non-judgmental kind of environment in which to do that, which was fantastic.

S: *And that didn't happen in your training practice then?*

T: You don't meet for coffee. They still don't meet for coffee, I think. Most lunchtimes, I ate on my own or with the receptionists who were wonderful, they were very very nice. But there was very little informal meet time, amongst even the partners, I think. I tried to encourage some of the others to come up but I know that the salary doctors were so busy that they didn't even have time to take that break.

S: *What was the relationship between them?*

T: Very strained. Very strained amongst the partners. It's not unusual for there to be low level disagreements at practice meetings.

S: *Were you invited to practice meetings?*

T: Yes.

S: *How did they tend to handle disagreements?*

T: It felt, in retrospect, I think a lot of things weren't really resolved. There was, not conflict, that's too strong a word, but it was clear that a lot of the partners didn't necessarily agree on certain things, which is a shame.

S: *But they didn't have a mechanism to try and solve that?*

T: Not outwardly that I was aware of, but then of course I wouldn't have been involved in the actual partner meetings.

S: *You weren't in the partner meetings?*

T: No.

S: *So it was just kind of general practice meetings?*

T: Yes. We had a practice meeting just before the practice meeting every Monday.

S: *How would you describe the practice in terms of its ___ in terms of what was important for the doctors working there?*

T: I just get a feeling that everyone strove to work hard. Everyone seemed to do their bit.

S: *Work hard towards what?*

T: Towards helping patients the best they could. Clearly after the first couple of weeks where you get to sit in on the occasional surgery, I didn't see people actually consult but they seemed generally a very good bunch of doctors.

S: *And when you say good bunch of doctors, what do you mean by that?*

T: I think they were all very competent. I didn't feel that a lot of them were necessarily...how would you put it...certainly the most senior partners in the practice were not really as friendly or necessarily keen to have lots of time to help the trainees. It sounds really opinionated when you say it out loud, but I think it was probably true.

S: *That's ok, this is your opinion and it's important you say how you perceived it at that time.*

T: In fact a couple of them would be quite genuinely unfriendly at times, it would be easier to go and approach some of your peers or salary doctors. I'd often speak to her if anything was reasonably simple, I didn't feel I had to go to my trainer.

S: *Can you describe that a little bit – was that coming during surgeries when you needed?*

T: During surgeries and in between surgeries. I think part of the problem was the lack of informal meeting is that a lot of people would go away for lunch or be clearly caught up in other things and it was often very difficult to find someone and on occasion, when I become duty doctor – about 3 or 4 months in they put you on duty doctor phase, which was pretty busy as their visiting rate is pretty high. I was left without a partner on site. I have a very, very clear recollection of me and the salary doctor being the only people in the practice one Friday afternoon and trying to juggle a couple of things. I didn't have anything majorly complicated to deal with that afternoon, but it would have been quite nice for, say my trainer to stay with me, or one of the partners to stay, to say "you're right" ...or not. And I ended up having to ask the good old salary doctor her opinion as well and I think that she felt, she was happy to do that but it shouldn't be her place.

S: *It sounds as if you were working quite a lot on your own?*

T: Not as supervised as I have anticipated no .

S: *How did that make the transition then into work, when you finished training there and you went to work elsewhere? How do you feel, on reflection that worked?*

T: Strangely, I was actually very well prepared for going into the workplace. Even, particularly going out as a locum because it's still quite solitary working as a locum. And I hadn't really anticipated that I would be a locum. I was hoping to find myself a salary job and just tick along and not have to worry about finding

work. But there was such a lack of salary jobs as you may well be aware, there was nothing that really came up that was the right thing. In fact, I did consider going for a salary post at this practice following that, but then after a great deal of reflection and discussion with my husband, I decided that I was probably happier just continuing to locum. I think overall, strangely, the environment really did prepare me. I was almost over prepared for being on my own and found it really wonderful going into xxx, it's an amazing practice. They're all very, very friendly and always welcome, it's fantastic, really, really good.

S: Is that in terms of the working relationship?

T: The working relationship, all the GP's get on like a house on fire, they're all just very, it's very much more of a relaxed atmosphere, despite the fact that the practice is probably just as busy as my training practice. In a different way, they have a lower visiting rate in comparison but they have a demanding population, so there's a lot of work, but it's dealt with with a smile. And there's a great deal of helping. If you were duty doctor in an afternoon and you were absolutely stowed out, your colleagues would do a few calls for you, in a gap. That would never have happened in my training practice. Never.

S: So do you think that sort of team work makes it a lot.

T: Absolutely amazing and vital. You knew that if you helped someone out that it would be reciprocated at some point. It meant that the work actually got done really well, it was generally more efficient. There wasn't someone doing unimportant admin who could perhaps be helping out doing call-backs or whatever. That was never the case.

S: How did this team support, how does it help you as a young doctor in terms of what is it that it gives you.

T: It gives you a feeling of, I guess what you're missing when you're away from hospital jobs is that peer support, so colleagues you know that won't think badly of you or support you if you want to ask advice or informally chat about patients. I think that for someone like me, who isn't as I said, reasonably shy but more outspoken than pre my reg year, it provides you with that kind of extra bit of confidence in that you know there are other people around there if you need a bit of help. You're not solitary working which is one of the things that is challenging about general practice.

S: Something about that kind of..

T: Yes, there's an extra element of the feeling that you're being backed up and you can rely on other people around you. I often felt that I was overloaded with work as a registrar and I think that a lot of things were, not necessarily palmed off on me, but perhaps should have been dealt with by others. I've never had that happen to me in any of my long term jobs since.

S: Do you think in your training practice, how did they view the trainee and their role in relation to the trainee?

T: Generally as a service provider. I during the year tended to go on a few courses and at no point was I ever given any study leave. I tried to as well take a couple of days, I can't remember, a lot of the partners were on holidays so I was told I couldn't have those days as there wasn't enough doctors. So you clearly weren't considered supernumerary in real time. So that was, you were given

extras at the end of the surgery just like anyone else. You were given a good amount of work, which I didn't mind, I enjoyed the work but yes, I was very much a service provider. There's no doubt about that.

S: You spoke about what was important to the doctors in that practice and you said that they were good doctors, so what is so different about them to the doctors you're working with.?

T: That's a good question, I had wondered about that and I did wonder about this group before I thought about applying for the salary job there, what was the difference and how could I make this surgery work for me. I think on a basic level, some of them are part time and some of them are full time. A couple of the GPs there very clearly have bigger roles in the health service and I know, I won't mention any names, there are a couple of people who work in the sort of drug side of things with the formulary and they clearly don't have as high a clinical input as the others. There was a wee bit of a feeling that the others ended up with a lot more work and things just come along paperwork wise in GP. I do think that some of them wanted slightly different things. They're all very different personalities, we all work together with different personalities and get on, but they did seem to be a few kind of personality clashes in the way people liked to do things and there was a little bit of a feeling amongst the staff outside of the partnership that they couldn't really approach if there was worry or approach if there was something they were concerned about.

S: Administrative stuff?

T: Yes, administrative stuff, it could be that sort of thing and then again, the nursing staff worked very hard and a number of them have not remained at the practice themselves and I think they just felt that they could work in a more friendly and informally supportive place.

S: What were the opportunities for you and for the non-medical staff of the practice to be involved in the decision making or have any initiative in making changes in the practice?

T: Not really any involvement. One thing I did involve myself in was an audit but that was, I did an audit early on in the realization that I might have to do one for the new exam. But I did do a little bit of audit with the guys. As far as decision making and things, we did significant event analysis, so we did a couple which I'd been involved with, looking at protocols and things. We'd had a patient who had been shocked, she'd been having a bleed in the practice and how we'd managed it and what was in the box, whatever. So there was a few things that we were involved in.

S: So that involved everybody?

T: That was just clinical staff. I think that was just clinical staff. I take that back if I was wrong but I think it was. I think the initial meeting did involve reception staff, because obviously they're involved in a situation like that. For deeper things for protocol driven sorts of situations, no, not really. I personally didn't. I don't know if any of the other trainees did.

S: And were you aware of any forms of meetings for medical and non-medical staff to get together and work things in improving the practice? Any formal meetings, was there opportunities for them to be involved in decision making in the practice?

T: The only real opportunity was the practice meeting which happened on a Monday and that was just clinical staff. As far as I know, it was purely clinical staff. It was more of a, it was very much a headings – “right, lets talk about what’s happened, who’s sick, who’s on the palliative care registrar” – it was very much driven by structure. I don’t remember there ever being a great deal brought up by any of the other clinical staff at those meetings. I think, I suspect now that the practice manager did meet with the administrative staff at other opportunities, but we weren’t involved in that, I was never invited. It was a very separate thing. And even that, I’m trying to think of what we did for the practice education afternoons, there was a feeling that there was only one that did involve them, they often did their own separate education.

S: *So they didn’t involve reception?*

T: Not always. I think there was just the one while I was there that involved reception staff but it was, I think it was more administrative so it involved them.

S: *What features of the practice do you think were particularly good for training?*

T: The workload. It might sound strange, but I think for a lot of people, having that amount of work – it wasn’t where you would go from a little country practice where you would have five patients in the morning and no house calls for your life, so you were busy. And I think laterally, at the end of the year, that was a good thing. Though I think initially it was a baptism in fire. I think from that point of view, certainly the workload. I did find it very difficult and I felt that I was getting too much at times so I guess that’s the balance isn’t it.

S: *So it’s on reflection now, that you’re saying that?*

T: Yes. For me, I thought the workload was too big, but I knew that a lot of trainees around me would have found that probably very, very good. They were very career driven, really wanting to get into the meat of it.

S: *When you say career driven, what do you mean by that?*

T: I think maybe the sort of people who wouldn’t mind staying three hours late to finish off a surgery and seven house calls. Whereas I’ve always had to maintain happiness and strive to not be too silly that way in staying late. I’ve never been happy to spend hours and hours extra every day staying late to make sure everything’s done. There are times which I potentially will have to do. I think overall probably it’s a wee bit too much.

S: *And so how does that relate now to where you work now in terms of the work load? How was that transition between working in that place to where you are now?*

T: I think I found working in the practices after training a bit easier, because it did feel like a little bit of a step back and I had a bit more time to deal with issues post-surgery. At my training practice I would easily have to do three house calls each day, whereas at xxx, there was always a doctor doing duty and they did all the house calls, because there weren’t as many. So I would be able to carefully sort my admin, do my referrals the way I wanted to them and phone people if I needed to. I didn’t have this time pressure which I had very regularly as a registrar. It actually hits the nail on the head – you just didn’t have the time to necessarily do things exactly as how you wanted to do them.

S: Is there something maybe about the way the work is organized?

T: Yes. Yes. The system certainly of having a dedicated duty doctor who doesn't give all the visits to elsewhere. I don't know if that would work at my training practice because of their visiting culture, I mean it's not unusual for them to have eight visits every day.

S: So when you say the visiting culture, do you think they over-visit?

T: I think, from certainly a lot of the visits I ___, there were couple of patients who were known to be able to go out to the hairdressers who wanted house calls. So its, again, that being difficult with the patient population, it means massively re-educating patients and whether that's something that anyone would try and sort or whether it's accepted, I don't know. I certainly found that quite a load. I enjoyed doing house calls, but I found it very difficult to do three and get my admin done, and have lunch and have ten minutes to clear my head. As a locum, I've never done a morning duty for them again, because I didn't want to. I didn't like the way it way it was organized, you ended up doing house calls, not terribly...I never felt that you had the time to spend with each patient properly, which I would have done elsewhere.

S: When you work in other places, you find that it was different?

T: Yes, very different. Even ad hoc locums – I do quite a few locums in (name of an area) as well and a couple of practices there, yeah they do give you a lot of house calls, but there's time factored for that. And you get a bit of admin time. I'm not saying they're all great – there's one that I work for regularly, where I'm always late. It's not unusual for me to work til three o'clock from just a morning session, but at least I know that I've had the time and the space and I'm not going to be kicked out of a room at lunch time.

S: You spoke about what are the difficult things. When you finished, kind of looking back, when you finished your training, how well did you feel you were prepared then at the time?

T: At the time, I was pretty well prepared, actually. I'll give them that credit. I think I was. The main thing that I felt was missing was a reality check, particularly for locuming, how the hell to go about it. I did a lot of self educating, speaking to other locums. Which is fine, but I think, there were a few people who went straight into partnerships from registrar and I have no idea how they would have done that. I would have never felt equipped to make that sort of decision.

S: Why is that? What was it you were missing, do you think?

T: I think partly it was because there was very little involvement of the registrar in the partnership side of things. I never at any point witnessed any meetings regarding financial matters of the practice or employment. Being an employer as a partner is a huge big deal and I would never have felt prepared to do that. I'll not be looking for a partnership for a long time, if ever, partly because of my career decisions. I'm going to be part time forever, I think. It was very much missing. I think our half day release did prepare us a little for that, but because of the pressure of exams, there was a lot of it dedicated to the clinical side of things as well.

S: What does being prepared mean to you?

T: for me it means being able to go into a new surgery with potentially a new computer system, new colleagues and still feel that you will be able to do a competent job.

S: *When you say a “competent job” what do you mean by that?*

T: Well, I think one of the big realizations when I finished my training was that medicine is the same everywhere. So to feel that you’re armed with the knowledge and decision making processes to still perform that job well, but not necessarily just in that familiar environment. Certainly as a locum, it’s a different environment every day. I certainly felt prepared in that way, in terms of the knowledge, absolutely.

S: *And how to make decisions?*

T: Yes, yes. And the consulting skills as well, which was the thing I worked very hard on in that year. I think that for me was the main thing.

S: *What is being prepared for you now? Is it the same thing?*

T: I think it’s probably different actually. I’ve never really thought about that. I think the knowledge should be taken as rote anyway. You should have that. I suspect that being prepared for me now would be including all of the how on earth do you manage self employment, what it means to be a partner and coping in that sort of job. So it would be dealing with more of the administrative side and the career planning side of things would contribute very much more towards being prepared.

S: *It’s quite interesting, having to make decision making and managing patients and things like that, that is kind of less of an issue for you in terms of preparedness?*

T: Yes, I felt that was fine. I think part of that is that you’re very self driven – you have to be. You’re very much taught that you’re part of the _xxx _ so a lot of this stuff is self directed anyway, so I was used to that. And I tended to over study a bit to be honest. So getting through the knowledge exam, I wasn’t too concerned about and the consultation skills side of things, again, very self directed. We set up a wee study group, a few of us did lots and lots of practice.

S: *When you were in your training year, you kind of said that you felt quite well prepared at the end, how did you know you were ready to work on your? How did it come about you understanding that “this is me, I can cope with it now”*

T: I would find that at the very beginning of the year, I would be asking lots of questions and not know where to find answers to questions. But come the end of the year, at the point where I started to feel prepared, I was getting through a surgery either – well, everybody asks questions – but maybe only asking one or two and actually being more independent about seeking answers to questions and feeling more confident saying to patients “come back and I’ll find out for you” , clearly if it’s not an urgent issue. And that was, that feeling where there was more comfort with the uncertainty that comes along with being a GP. For me, that was the main thing – starting to feel that I was able to do things more independently. Even to this day, I’ll still ask the odd question, as I said, discuss with colleagues – you have to, it’s part of the work. But not to the same degree as the very beginning.

S: *It's part of learning.*

T: It is very much part of learning and for me its very much that kind of reflective discussion thing.

S: *In terms of thinking about your training practice, what kind of aspects were particularly good in preparing you for the job of a GP. You've talked about the workload.*

T: I think the patient mix was quite good. It wasn't a polar type of practice. It wasn't very, very middle upper class or very, very deprived. There was quite a mixture of patients and because it was a good mixture, there was lots of chronic disease but also a lot of young folk with acute problems. So a very good patient mix for learning. (unclear sentence)

S: *We spoke about the work in terms of...What was it in the way you went about and did things in that practice that you think facilitated independent practice?*

T: Partly that you had no choice. Fly by seat of pants or don't fly at all[laughing]. So it was always highly encouraged that you just get on with it. I think just generally, this solitary environment that was thrust upon everybody, I mean, everybody worked like this. You were really encouraged to get used to the fact that you will be working on your own. I, that's not how I naturally do things. I'm very much more of a team type person, I like to know that there's other people around. Not as a crutch, but it's nice to know that you can take on the expertise of other people. You were chunked in at the deep end, very much so. You didn't have any choice.

S: *How did they ensure the balance between you being able to make decisions on your own and them making sure that you made the right decisions?*

T: Initially, I would go through my surgery with my trainer. And we would discuss things, albeit quite briefly. We would go through cases and occasionally do a random case analysis: pick a case of the day, it could be absolutely anything and we would go through it and just check why did you decide to do this, what else could you have done. So we did go through cases. But laterally, my trainer unfortunately had quite a troublesome year and come the end of the year she was absent a reasonable amount. So I had less of that at my disposal come the end of the year. It was encouraged to sit down and go through some of these cases, but it wasn't something you did regularly. We did similar things with referrals as well, to make sure I wasn't over referring, that I was including the right information and that. I've done that since actually as a locum for appraisal. That was actually very useful and we did that on a few occasions. But you did feel like you could perhaps be doing god knows what and not necessarily be picked up. But I think that you knew that if you were in any doubt, to ask. And that was the difficult part, finding someone or feeling welcome to share your doubts. I often felt quite singled out maybe for "why don't you know this" when perhaps I was trying to be super honest and saying "well, I don't know this, that's why I'm asking".

S: *It was almost kind of frowned upon?*

T: yes, it was quite confrontational sometimes. Just the way of going with your doubts and the questions that I had.

S: *And this confrontation, was it from your trainers or was it from other people in the practice?*

T: From my trainer and the other trainer in the practice had a slightly similar manner. So I picked my days carefully. I'm laughing about it now, but it wasn't funny at the time!

S: *Yeah, I can imagine. So how did they introduce (complex patients?) to you? Was it just whoever came through the door?*

T: Yes, someone just came through the door and you'd end up obviously as a GP, as who ends up with people who turn to you, take a liking to your manner and feel comfortable speaking to you, so I did end up with quite a few complex patients as returners to me. I often would take them along to tutorials and say this is where I am with this, I would really like to discuss where to go next. It was very much again self driven. But yes, they would just come through the door.

S: *You mentioned, going back to what you said about when they had questions, sometimes they would say "why don't you know that" it was a bit confrontational, how did that make you feel? How did you react to that and what impact did it have on you?*

T: I found it very, very difficult. It wasn't a manner I am used to and I think that a lot of the time it did, I don't want to be dramatic, but I would think "should I know all of this?" Am I working hard enough, am I not cut out for this? So I would start to introduce little doubts and I wasn't in top spec that year – I was fine, but I wasn't great. So it would introduce doubts in my mind and it also did make me reluctant to divulge too much. I would often try and independently sort it out because it was often not worth the wrath that would ensue. And again, I would speak to other colleagues about it or in half day release, we would often bring up cases that perhaps had not had the chance or had the chance but not really gotten anywhere with and talk through them there.

S: *So you looked for the answers elsewhere?*

T: Yes. Occasionally I did. Which is sad. I didn't really feel that I should be in that position, but I did have to find answers and if I felt that it was becoming a bit more of a harder situation than it ought to be, I would take a more pleasant route.

S: *Very difficult really, what you're telling us. Can you discuss any particular experiences that provided good learning opportunities to you?*

T: Yes, certainly the videos we would do in surgery – I mean, I hated doing them, I don't think anybody enjoys doing them, but you do get used to it – I found it very, very useful and got a great deal out of them I actually found that less confrontational, I'm not sure why that was less, perhaps stressful than the trainer, I don't know what the problem was, but I found them great. So I certainly found them great and I was certainly very well prepared for doing the CSA exam. Partly also because I had done a lot of role play in study sessions early. We met every night for a few weeks before the exam. But that was outside. Certainly, going through the videos was very useful. I did that both with my own trainer and with some of the other trainers in the practice. Got quite a lot out of it.

S: *We kind of spoke in general terms about situations where you were uncomfortable in the practice, can you tell me about something specific that happened?*

T: I think that, it was a Friday afternoon, on call, no partner in the practice and I had done a house call to a lady who had had some strange neurological symptoms. I had been out to see her and I just wasn't 100% happy, she hadn't had a stroke or anything. But because I was in doubt, I didn't have anyone around to ask and there was nobody I could phone, I had a chat with the stroke hotline, and they were great. So we decided it would probably be better to go and visit her in the next week and take some bloods. I can't remember the exact case. And I brought this up at our tutorial at the beginning of the next week and brought it up as a "did you have any difficult cases recently?" I think was the question. And I brought this up and it ended up very, very confrontational. "why didn't you do this, why didn't you seek advice from such and such" or "why are you finding this so difficult" I think was the question I had and on this particular occasion I remember getting quite upset about it, which is not really my style. And not really feeling that I had got anything out of that conversation. The woman was fine, I went to go and see her again that week and her son was very grateful for everything we had done and it turned out fine in the end. This was one of the cases where I actually needed someone to tell me "well, maybe you should have done this" or "actually, you did fine, because you sought advice". I didn't really feel I got that. I remember that being quite a .(gasp) .that was a bad day kind of feeling when I went home. Again, reflecting on it, it's very difficult to think well, was that just a bad day for me, was I just slightly touchy? I don't know.

S: *Something about the way...*

T: Certainly, it wasn't a happy interaction. It was quite difficult

S: *Something about the way they brought criticism on it?*

T: It was part of the questioning, I think. It was very direct. "So why did you do this, why do you find it so difficult" vaguely pushing, pushing, pushing and I think pushed me just a little too far.

S: *Not acknowledging perhaps how you are as a person?*

T: Yes. It was quite tricky.

S: *We spoke about the trainer, but I haven't asked you specifically. I'm going to ask you a bit more specific questions about your trainer. What aspects of her were good for training, do you think?*

T: I think the experience, it's not personality, but certainly very experienced, kind of logical. I think her very proactive nature, encouraging you to work and find things out was great. I found that very good. And the occasions of supportive nature and coming around to my house for lunch, which was not very often, but certainly that was one aspect that did appear but it was very good and did allow a bit more of informal chat.

S: *But it was a bit sporadic?*

T: Very, very sporadic. It wasn't consistent.

S: *And what aspects did you find difficult?*

T: I think her personality and my personality were very different. A quite confrontational character. I think the...I'm trying to be nice...

S: *You don't need to be nice*

T: I know, I know. Certainly, specifically very confrontational and spiky. Quite difficult occasionally to work with and I guess gauge her moods. There would be times where I would think that I would just hold off till tomorrow to ask that and just lets not create a situation today. So that was definitely something I found very difficult. And I know that I said pushing me was very positive, but at times she pushed me too far and I think I work hard and sometime to my detriment at times, I worked too hard, so I don't think I really needed that extra push. I sometimes found that more of an emotional burden than anything else. It was always like "am I not doing enough" whereas actually I was doing far too much and that extra pressure wasn't great. That's really the main thing.

S: *What was she like as a doctor?*

T: she was very well liked as a doctor and she had lots of very faithful patients. I've not seen her consult a great extent and it's been quite a while since I've seen her consult, but again she's got quite a direct manner as a doctor. She's not one of these touchy feely doctors. She can sometimes, she'll bring that out if required but she's generally quite direct and most people really like that. It's something I like as a patient so she's generally very well respected for that.

S: *What was important to her as a GP?*

T: I think she would occasionally reflect on experience and reflect on the experience she had and certain things that she was very careful to not miss now, just from previous experience. I got the feeling that she wanted to do a really good clinical job by the patients. She never really talked about the more interpersonal side of things but she certainly wanted to make sure that she was doing a very good job of the nitty gritty of the medicine. She certainly had a lot of patients that who had mental health problems, so she clearly did do that job well but I think only certain people would perhaps have warmed to the manner. It was slightly different.

S: *So you haven't had really too many opportunities to see her consult?*

T: Not really, no. The way that it worked was that I had the day release pre to starting the registrar year was used as induction. So when I actually started, I was straight into consulting, with the occasional attachment to the pharmacy (?). There wasn't a great deal of tandem consulting happening. I would find that very intimidating, actually. Incredibly intimidating. ___ palpitations and breathing difficulties. Which is never very enjoyable.

S: *How did that make you reflect on yourself, seeing what she was like in terms of how you want to be?*

T: I'm a complete polar opposite. It really encouraged me to be extremely patient centred ___ use of jargon. Which has pros and cons.

S: *What do you mean by that?*

T: I've tried very much to listen to patients, to try and give them time to not judge – I'm not saying she does – and you know, to really use the skills that have been learned to make joint decisions about things. I'm not bolshy apart from the patients I have to be with at xxx who need that. I tend to be more patient led with things. I'm not really direct – I'm direct when I need to be – but I let patients lead things a bit more. I think it's probably made me more of a touchy feely doctor than I expected I would be.

S: *And you felt that her approach was the difference?*

T: It was, yes.

S: *So in what way? Was it doctor centred?*

T: not necessarily doctor centred, but I think far more direct and perhaps less time spent talking about how things would make you feel, what was their experience of it. I'm sure she probably did, I mean I haven't, as I said, I haven't seen her consult for a long time and it was only a very short period, but the vast majority of my consultations would go into that, unless it really is something like, what to do with your cholesterol.

S: *But that's the impression you got?*

T: Yes. That's the impression I got. Whether that's fair or not.

S: *We talked about the relationship between the doctors in the practices and we talked about how the decisions were made in the practice and your involvement in it, or lack of it. What about the control over the work that you had? How much control did you have over your week and how your week was structured? How much input did you have into it, kind of saying, that you're used to consultation times?*

T: Very little. Very little. I remember, I mean I was down to 10 minutes by November, which I managed. I remember it being that I thought we would maybe go down to 10 minutes in November, when I was used to that. But it was more of a, it wasn't really "how do you feel about it" – you can see the way it was framed: "you *are* going to 10 minutes". So, very little. I have to say that come the end of the year when the half day release stopped, I actually ended up not getting my half day any more. So I was working 9 clinical sessions. At the time, I couldn't be bothered to argue that at all. It wasn't worth the energy because I had failed to get study leave and everything I just thought "forget it" and just write it off. So I was being worked very hard. I didn't get any control of it, it wasn't discussed, it was a "well, we'll have you consulting on the Thursday now as well" because I normally had that as a half day for maybe e-portfolio and all the gubbins that comes with that. So I would have the Wednesday afternoon off, one day in the week, because I basically disappeared. And I don't know if that's what was supposed to happen – I suspect not, but that's what happened.

S: *you weren't really involved in the partnership meetings, but did you have a feeling about how they made decisions in that practice?*

T: I never really got a very good impression of where the decisions came from, to be honest. I think there were a couple of dominant voices in the practice, but I never ever got, or witnessed a solid decision being made about something clinical at any of these meetings. They may well have been done at the practice meetings.

S: *But you weren't involved in that?*

T: No. Not at all. There didn't seem to be many meetings we were at there were occasionally disagreements about things and at a lot of them, nothing was ever terribly resolved ever.

S: *How do you feel now when you're looking for jobs, what is it you're looking at when you go into those locum practices, what's the sort of things that are important to you?*

T: For me, it's knowing that people work as a team. That it's a friendly atmosphere and there's none of this kind of strained, underlying stress that you often feel in a practice, where there's something happening – there's unhappiness, there's unrest. If there's a feel of that, then I don't want anything to do with it – it doesn't foster happiness at work and for me that's beyond the most important thing. I think you can work in worse places if you've got nice colleagues and you get along together really well. So that is definitely the main thing. And I have to say that the way things are organized as far as duty doctors and admin has quite an influence on me as well. And I have to say that the system that worked at xxx where you'd end up being divvied out lots of house calls and the salary doctors and the registrars got their's first and the partners got them if there were any left. I'm not joking, that's exactly what happened. I hated it. It was, it felt like slave labour. I remember getting four or five one morning and I actually, quite unusually, went to my trainer and said "I can't do these, I'm sorry" and she asked "don't you feel up to it?" and I said "no, I don't have the time". I had to go at a certain time; I think it was a wedding.

S: *not a very democratic workplace...*

T: No, not in any shape or form. And it did make me slightly opinionated when I was giving out house calls. I would make sure that the partners got a house call. It's terrible, it makes you, it's almost a revenge tactic. I tried to be equal, but it was locums and registrars got house calls first, then salary and then partners last. That's generally how it happened.

S: *So that's the sort of thing you're looking at when you...*

T: Definitely. It's just that, you know, that there's some sort of clarity in what's happening, that there's an understanding, there's no underhandedness and equally, how locums are treated at a practice is a major reflection on what a practice is like. You can really get dumped on as a locum, but some practices are fantastic and despite the fact you might only be there for four hours, its "come to coffee, come to lunch before your next surgery" - there's a huge contrast between practices, absolutely.

END

**Appendix 4: Ethical approval- NHS South East Scotland
Research ethics Committee and Edinburgh University ethics
Moray House ethics sub-committee.**

South East Scotland Research Ethics Service

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Name: Sharon Wiener-Ogilvie
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Your Ref:
Our Ref: 10/S1101/40
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Dear Sharon,

Full title of project: The learning environment in General Practice Training and its relation to 'preparedness for practice'

You have sought advice from the South East Scotland Research Ethics Service on the above project. This has been considered by the Scientific Officer and you are advised that, based on the submitted documentation (IRAS form, CV, interview schedule GPs, interview schedule trainees, email invites, participant information sheet, research protocol), it does not need NHS ethical review under the terms of the Governance Arrangements for Research Ethics Committees in the UK. The advice is based on the following:

- *The project is an opinion survey seeking the views of NHS staff on service delivery.*
- *The project is an opinion survey seeking the views of NHS staff on a service development*

If this project is being conducted within NHS Lothian you should inform the relevant local Quality Improvement Team(s).

This letter should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements. However, if you, your sponsor/funder or any NHS organisation feels that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further. Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

You should retain a copy of this letter with your project file as evidence that you have sought advice from the South East Scotland Research Ethics Service.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Alex Bailey', written in a cursive style.

Alex Bailey
Scientific Officer
South East Scotland Research Ethics Service



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Sharon Wiener-Ogilvie
NHS Education Scotland

27 July 2010

Dear Sharon

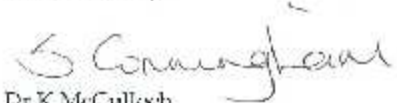
The training environment in General Practice and Preparedness for Practice

The School of Education Ethics Sub-Committee has now considered your request for ethical approval for the studies detailed in the above application.

This is to confirm that the Sub-Committee is happy to approve the application and that the research meets the School Ethics Level 1 criterion. This is defined as "straightforward" non-intervention, observational research (e.g. analysis of archived data, classroom observation, use of standardised questionnaires)".

A standard condition of this ethical approval is that you are required to notify the Committee, of any significant proposed deviation from the original protocol. The Committee also needs to be notified if there are any unexpected results or events once the research is underway that raise questions about the safety of the research.

Yours sincerely


Dr K McCulloch
Convenor, School Ethics Sub-Committee

Appendix 5: Information to participants



What is the aim of the study?

The aim of the study is to explore the way in which GP trainees and early career General Practitioners describe their learning environment in general practice and the way they perceive this learning environment to impact on their preparedness for practice.

Rationale for the study

There are a wide range of theoretical perspectives on workplace learning and the characteristics of the environment conducive to learning. Nevertheless, little is known on how the workplace learning environment of doctors in training impacts on their professional preparedness. In particular, little is known on how the experiences of general practice specialist trainees during training, whilst in general practice, are linked to their perception of preparedness. As the component of training in general practice setting has increased from 12 to 18 months, and with the RCGP arguing for the extension of General Practice training to five years, there is a need to gain further understanding into the way in which the general practice learning environment impacts on preparedness for practice.

How would you be involved in the study?

We are looking to interview early career GPs, and GP Speciality Trainees in the final year of their training (who have passed AKT and CSA).

Interviews will be face to face whenever possible. It is estimated that interviews will last between 45 minutes and an hour. Telephone interviews may be conducted with early career GPs who have moved away from Scotland.

How will information from this study be treated and stored?

Ideally, we would like to record all interviews in order to assist us with the data analysis. Recorded interviews will be stored in a file which will be password protected and accessed by one person (the lead researcher, Sharon Wiener-Ogilvie). The audio files will be transcribed by an administrator who will be kept blinded to interviewee identity and will sign a confidential statement. Once the interviews are transcribed, all identifiable information will be removed (such as names and locations). Thematic analysis of the interviews, informed by grounded theory approach, will then take place, assisted by NVivo software. All information obtained via the interviews will remain anonymous and will not be shared with or linked to specific practices. Some of the anonymised text will be shared with a small group of educators and with researchers from the school of education, university of Edinburgh supervising the project. Anonymised data will be also used in any publications. Additional security measures will be put in place in line with the advice received from NHS Education Scotland Caldicott Guardian.

Should you require additional information on the research please do not hesitate to contact Sharon Wiener-Ogilvie at the GP unit, The Lister, 11 Hill Square EH8 9DR, telephone number: 0131-6514346.

Appendix 6: Consent form

CONSENT FORM



Title of Project: the learning environment in General Practice Training and its relation to 'preparedness for practice'

Lead Researcher: Sharon Wiener-Ogilvie

1. I confirm that I have read and understand the information sheet dated for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand that extracts from any written or verbal information given might be quoted in any published material however this information will be anonymised and my identity will not be disclosed. ☐
4. I agree to take part in the above study ☐

Name of participant..... Date.....

Signature.....

Name of Researcher..... Date.....

Signature.....

Appendix 7: List of initial codes generated using NViVO

[-] Practice	0
[-] work intensity, workload	17
pressure to decrease appointment time	4
value trainee, trust	25
[-] trainee degree of control	11
MUTUAL AGREEMENT ,DECISION-empowering	6
trainee perception of being used	12
trainee learning style- adaptation to	6
[-] team work	0
working together	2
working seperatly- doing thier bit	5
togetherness, being part of	12
team work security safty netting	1
team work -efficiency	4
sharing of work, responsibility equally	19
relay on, mutual help, support	11
Information sharing	15
focus on team work, intergartion , unity	9
ethos of unity in approach , values and attitude	12
Drs getting on well	13
confidence- can relay on	5
common goal	5
[-] teaching , training priority, enthusiasm	3
teaching training low priority, low enthusiasm in general	7
teaching training high priority	17
[-] support	1
tailor support to need	17
supervision at all times	19
protection	11

...	lack of support	9
...	from all the team	8
...	being explicit about the support offered	6
...	striving to improve, ongoing evaluation ,earning from mist	5
...	specialist clinics, experties of partners	13
...	practice-patient relationship	27
3-...	practice staff	1
...	trusting or good relationship non medical staff and doctor	12
...	staff driving change	2
...	seperation staff and Drs not including staff in discussions	13
...	not considering staff	2
...	not appreciate value staff	6
...	inclusion of staff in discussions or decision making	18
...	Drs,partners only drive change	9
...	consideration of staff, support	8
...	appreciate, value staff, staff important	8
...	practice learning style versus trainees learning style	4
3-...	pracle as role model	7
...	does not relate to ethos	4
...	Abillity to relate to the ethos of the practice	15
...	physical facilities	12
...	patients and business needs	19
...	orientation to community service	3
...	organisation of work efficient V non efficient	16
...	more than one trainer or other partners	19
...	learning seperatly, or in isolation	0
3-...	learning needs trainee	3
...	proactive in relation to exploring trainees needs	2
...	practice understands trainees needs and addresses them	19
...	Involving the whole team in adresssing trainee needs	1
...	does not respond to trainee needs or does not understan	10
...	learning as a team	13
...	keeping in touch with	4
...	Isolation	3
3-...	Innovative, encourage initiative	3
...	Open to external ideas	5
...	involvement with externals- take new initiatives	3
3-...	Informal social interaction, coffee break	5
...	opportunities to resolve contentious isseus, see how part	7
...	opportunites for reflection	4
...	lack of Informal meetings or difficulty in attending	11
...	informal learning	19

built rapport, unwind reduce stress	14
builds understanding of trainee learning style and needs	7
baiss for development of trust-,discuss uncertainties build	15
a reflection of inclusiveness	14
inclusiveness of trainee, participation in, motivation and c	12
transparancy versus secracy about how practice run	18
separation between trainee and Drs	17
involvement in	8
inclusion in meetings	17
Included in decision making, listened to, inclusion in discu	20
honesty	5
hierarchial-non	15
Hierarchial	14
Forward thinking	2
striving to improve, ongoing evaluation ,earning from mist	9
resistence to change	12
Openess to criticism, openness to change	9
Insight to thier problems- which they're happy to discuss	5
exam preparation- focus on	1
employment on completion of training	3
doing extra for no financial gain	3
disagreements, tensions	6
system to negotiate disagreements	7
strained relationships	14
reduced social interaction	1
affect on training	9
not affecting trainee	3
good relationships	18
continuity of care-more efficient	9
caring for trainee, friendly, repond to trainee needs or con	7
approachable , welcoming	16
encourage trainee to ask	9
approach to work	13
patient demography	2
number of drs, trainers	4
follow employing practi	17

Tree Nodes

	Name	Sources	Ref
	working in another prac	17	54
	trainer	0	0
	welcome, approachable, comfortable with	9	
	made uncomfortable to ask	5	
	understands , relate to trainee	12	
	trusting relationship- confidence in	8	
	trainer trainee relationship	4	
	trainer honest with trainee	7	
	sharing clinical uncertainties with	10	
	not trusting	7	
	trainers communication skills, patient skills	3	
	trainer-patient relationship	13	
	relationship with patients- good job	12	
	trainer role model	20	
	admiration of trainer - manage multiple roles	6	
	admiration of trainer	14	
	trainer place in the team	7	
	tandem, joint consulting	13	
	setting expectations	4	
	high expectations of trainee	3	
	accepts trainee 'not knowing'	1	
	professionalism	9	
	pressure on trainee, pain, pushed, difficult	12	
	personal relationship with trainer	14	
	caring, empathy, closeness	8	
	parental relationships	9	
	length of service- experience-part time	16	
	learning style , needs	11	
	adaptation of trainer to trainee learning style and needs	17	
	knowledge of assessment requirements	3	
	judgemental, doubting	11	
	intimidating	4	
	interested in trainee	4	
	insensitive, not responding to trainees emotions, not und	4	
	implicit rather v explicit trainer behaviour	3	
	hierarchical , non hierarchical relationships	13	
	feedback, questions	0	
	timing	3	
	superficial verseus in depth, stractured feedack	4	
	regular positive feedback increases confidence	8	
	practical solution, insightful feedback	21	

Tree Nodes

Name	Sources	Ref
positive feedback when trainee done well	8	
no right or wrong answers, need for reassurance	12	
learning from feedback	7	
honesty, lack of honesty no trust	18	
formal veruss informal	4	
feedback without undermining trainee	16	
feedback from trainee on trainer	1	
feedback damage confidence	12	
feedback advise from other partners	1	
answers versus joint discussion,or encouraginf trainees m	9	
expectation of support from trainer	12	
reassurnace by trainer increase confidence	14	
differences between trainer and trainee personality and m	4	
difference personality,manner trainee and trainer, how yo	12	
consistency in thier approach.to trainee or lack of it	2	
conflict between trainee perception , model of GP, conflict	14	
commitment to training, enthusiasm	5	
clinical knowlege	6	
challenging trainee	9	
career advice	7	
being valued by trainer	18	
advocacy, mentoring,outside ear	5	
trainee- blaming them	6	14
preparadness	0	0
workload, stress with workload	8	
Workload and job satisfaction	1	
work- life balance	7	
light workload	1	
heavy workload reduces opportunities for other	10	
Heavy workload- preparing	14	
Heavy workload and its effect on patients management	10	
working independently- not having to ask	19	
when start to look at doing extra or at specialising	3	
variey of clinical interest in practice	3	
trainer confidence in trainee	12	
self employment- management of	5	
primary care organisational - understanding of	3	
patient type	7	
patient mix- good	12	
patient gender	1	
patient expectations	5	
Deprivation (deprived area)-challenge- communication wi	14	
affluency	7	

Tree Nodes

	Name	Sources	Re
[-]	partnership- feeling of readniess , confidence	9	
	making decisions	3	
	getting on with people	5	
	opportunities for trainee to teach	1	
	OOH	1	
	not an expert, knowing limitation and strengths	13	
	knowlwge as a base	12	
	knowledge of hospital services, how to refer, community se	9	
	It system- familiarisation with different systems	8	
[-]	involvement in partnership side	6	
	seeing how conflicts are solved	6	
	lack of involvevement	7	
	involvement in, initiatives, participation in leads to confide	10	
	importance of social aspect in patient management, holisti	11	
	identifying learning need and addressing them	8	
	hospital relationship with GP	2	
	hdr	4	
	future employment- knowing what to look for	19	
	formal teaching	10	
	feeling that system is safe for patients, safety netting	8	
	feeling tcomfortable with system	12	
	exposure to variety, complexity, adequate numbers	20	
[-]	experience working as part of team	4	
	not witnessing staff involvement	0	
[-]	exame	1	
	WPBA	6	
	pressure off	3	
	passing exam as a landmark- increase confidence	8	
	exam preparation	13	
	encouraged to be self directed, autonomy, ownership, give	32	
	emotional readiness	6	
	difficult relationship- dealing with, dealing with difficult situa	13	
	desciption of preparedness depends on current work	10	
[-]	decision making process	3	
	less stress improves decision making	2	
	knowing where and when to refer	3	
	being decisive	11	
	critical incident, SEA, complaint, errors	13	
	coping with isolation as a measure for independence pract	15	
	consultation time, time management	24	
	consultation model, consultation skills	16	
	confidence- takes time	10	

	Name	Sources	R
☐	confidence		12
	feedback from other Drs,patients		8
☐	bussines side of GP, partnership- giving and insight		13
	Knowledge of business side increases confidence		17
	awareness different doctors diff views, style of consulting		24
☐	aware how staff is managed, importance of relationship wi		9
	not aware staff management		5
	aware how decisions are made		16
	accepting, managing uncertainty, risk, complex situations		16
☐	ability to adapt		15
	urban to rural or visa vera		3